Association des médecins psychiatres du Québec

Access to medical assistance in dying for people with mental disorders

DISCUSSION PAPER
NOVEMBER 2020

Provide appropriate care.
Recognize suffering and autonomy.
Respect the right to dignity.

Summary

Members of the committee

Karine J. Igartua, psychiatrist

President of the Association des médecins psychiatres du Québec (AMPQ)

President of the AMPQ since 2013 and psychiatrist at the MUHC for the past 20 years. Dr Igartua works mainly in psychiatric emergency services at the MUHC and MUSIC, a specialized clinic that she co-founded to assist people struggling with gender identity or sexual orientation problems. Since the start of Dr. Igartua's first term in office, the AMPQ has issued several position statements on societal concerns, notably medicolegal assessments and cannabis, and, more recently, distress in young people, with the creation of the Mouvement Alphas Connectés.

PSYCHIATRIST MEMBERS OF THE ADVISORY COMMITTEE:

Mona Gupta, psychiatrist

Chair of the AMPQ's Advisory Committee on MAiD

A psychiatrist at the CHUM and full-time researcher at the CRCHUM in Montreal. Dr Gupta is also an associate clinical professor in the Department of Psychiatry and Addictology in the Faculty of Medicine at the Université de Montréal. The broad theme of her research work concerns the interaction between ethics and epistemology in psychiatry. Dr Gupta is currently leading a research project funded by the CIHR on the exploration of psychological suffering in the context of a request for medical assistance in dying (MAiD). She is actively engaged in the bioethics community as both chair of the Bioethics Committee of the Royal College of Physicians and Surgeons of Canada (RCPSC) and senior editor of the journal *Philosophy, Psychiatry and Psychology*.

Guillaume Barbès-Morin, psychiatrist

Vice-president, AMPQ

A practising psychiatrist in Rouyn-Noranda for approximately 12 years, Dr Barbès-Morin has been an AMPQ director for seven years and became vice-president in 2018. He has also been active as vice-president of the Executive of the Conseil des médecins, dentistes et pharmaciens (CMDP), and as head of the regional department and co-manager of the Mental Health division.

Theo Kolivakis, psychiatrist

Dr Kolivakis has practiced general psychiatry at the MUHC since 2002, and has sat on the AMPQ's Executive and Board of Directors for six years. He is the coordinator of the Schizophrenia Tertiary Service (STS) and co-director of the Neuromodulation Unit at the MUHC. Dr Kolivakis is also an assistant professor in the Department of Psychiatry at McGill University.

MEMBERS OF THE COMMITTEE

Jessika Roy-Desruisseaux, geriatric psychiatrist

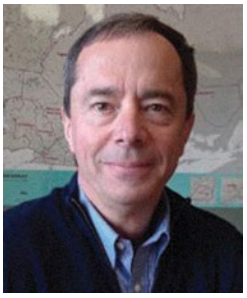
Sherbrooke

A geriatric psychiatrist practicing at the Institut universitaire de gériatrie de Sherbrooke since 2013, Dr Roy-Desruisseaux sat on the Board of Directors of the AMPQ from 2009 to 2017, and chaired the Geriatric Psychiatry Committee and the End-of-Life Care Working Group from 2013 to 2017. She is a member of the AMPQ's Advisory Committee on MAiD and an associate professor of psychiatry in the Faculty of Medicine and Health Sciences at the Université de Sherbrooke.

Evens Villeneuve, psychiatrist

Quebec City

Dr Villeneuve is an associate professor in the Department of Psychiatry and Neurosciences in the Faculty of Medicine at Université Laval and director of the Bureau d'assistance aux personnel enseignant under the Vice-décanat à la Responsabilité sociale. He is also a psychiatrist specialized in the assessment and treatment of severe personality disorders at the Institut universitaire en santé mentale de Québec (IUSMQ), where he founded the Centre de traitement Le Faubourg Saint-Jean in 1996. He practised family medicine for 10 years in the Trois-Rivières region before going on to specialize in the treatment of personality disorders at Stanford University in California (1993-1994), and later, in psychiatry at Université Laval (2009-2013).



René Cloutier, Director General

Réseau Avant de Craquer

Director General of the organization Réseau Avant de Craquer since May 2018, a federation of families and friends of people with mental illnesses. He previously held senior executive positions in the civil service and the health and social services network. He holds a bachelor's degree in occupational therapy and a master's degree in public administration, and was awarded the Prix Roland-Parenteau 2013 by the École nationale d'administration publique (ENAP). Mr Cloutier agreed to sit on the AMPQ's Advisory Committee on MAiD to bring the voice of members of the community into the reflection process, given the ethical societal issues that are particularly complex when it comes to mental health.

Simon Courtemanche, patient-partner

CISSS de Laval

Simon Courtemanche has been a service user/partner since 2017 at the CISSS de Laval. Notably, he is involved in the *Aire ouverte* and *Let's Talk About Health* projects. Since 2018, he has worked with the team from the Direction collaboration partenariat patient (DCPP, or patient partner collaboration directorate) by giving courses on ethics and collaboration in health sciences (CSS). In addition, he has been a member of the advisory committee for the protocol model concerning confinement in health facilities (P-38), and is active with the CEPPP, SRAP and INESSS. In his spare time, Simon studies full-time at the Université de Montréal in the field of health and social sciences. He is a young person who has found his place after years of struggling with illness and who now wishes to help improve healthcare services.

Preamble

The AMPQ's advisory committee on medical assistance in dying was formed in late January 2020 just after the 2019 decision in the Truchon-Gladu case (Truchon c. Procureur général du Canada, [2019] QCCS 3792) and just before Canada introduced Bill C-7 in response to that decision. A few short weeks later, society was swept into the all-encompassing waves of the coronavirus pandemic. The pandemic brought into sharp focus many issues and problems that plague us as humans and as societies, not the least of which is our relationship to death, dying, and loss. The issue of assisted dying may seem to be less pressing at a time when all members of society are being called upon to prevent death. However, throughout this turmoil, people with serious medical conditions have continued to suffer. Their needs, including for some their wish to receive medical assistance in dying, continue to be expressed. In consideration of these needs, we have pursued our work despite the enormous challenges faced by our healthcare system at this time. This document is the result of these efforts.

It is a privilege for the AMPQ to have been invited to provide recommendations concerning the practice of MAID MD-SUMC. As psychiatrists, it is our life's work to relieve the suffering of patients with mental disorders and give comfort to their significant others. MAID MD-SUMC challenges us to think deeply about the goals of our field and the duties we owe to our patients.

As a professional association, we are well positioned to understand the practice needs of psychiatrists in addressing the issues involved in the practice of MAID MD-SUMC. While we have insights as to what our patients and their families experience in the course of living with and supporting those with mental disorders, we believe that good practice guidance emerges from collaborative work with those with lived experience. For this reason, we are grateful to the Réseau Avant de craquer as well as the Direction Collaboration et Partenariat Patient at the Université de Montréal for identifying individuals to serve as committee members. We also recognize that our colleagues in other health disciplines have an important role to play in understanding our patients' experiences and their reasons for requesting MAID. When it is time to update this document, we hope that these professionals will be involved. We also suggest that the revision process include consultation with a range of patient and community representatives, particularly from Indigenous communities.

Over the last five to ten years, a great deal of information—research, commissioned studies, independent reports, and practise guidance from other countries—has been produced on the subject of assisted dying MD-SUMC. The committee did not undertake its own primary research. Instead, we drew upon the wealth of secondary sources to inform our recommendations. A complete reference list can be found at the end of this document. Due to time constraints, we did not undertake the formal procedure associated with the development of practice guidelines nor should this document be considered as such. Rather, through engagement with existing sources and a process of open debate in a series of meetings, we arrived at the recommendations contained in this document that are specific to Québec's particular sociodemographic, geographic, legal, and health system characteristics. We consider the resulting report to be an advisory document based on both clinical and ethical norms for psychiatrists and, indeed, any clinician who receives a request for MAID MD-SUMC.

Abbreviations

AMM: Aide médicale à mourir

AMPQ: Association des médecins psychiatres du Québec

AMM TM-SPMI: Aide médicale à mourir—Trouble mental—seul problème médical invoqué

AREOLC: Act respecting end-of-life care

BRAMM-SM: Bureau régional d'aide médicale à mourir lors d'un problème de santé mentale

CISSS: Centre intégré de santé et de services sociaux

CIUSSS: Centre intégré universitaire de santé et de services sociaux

CMQ: Collège des médecins du Québec

CSFV: Commission sur les soins de fin de vie

EAS: Euthanasia and physician-assisted suicide (Netherlands)

KNMG: Royal Dutch Medical Association

LCSFV: Loi concernant les soins de fin de vie

LEIF: Life-End Information Forum/Forum d'information sur la fin de vie

MAID (also MAiD): Medical Assistance in Dying

MAID MD-SUMC: Medical assistance in dying where a mental disorder is the sole underlying medical condition

MD-SUMC: Mental disorder is the sole underlying medical condition

NVvP: Nederlandse Vereniging voor Psychiatrie (Dutch Psychiatric Association)

RTE: Dutch Regional Euthanasia Review Committee

SCEN: Support and Consultation on Euthanasia in the Netherlands

SRMMB: Société royale de médecine mentale de Belgique

TM-SPMI: Trouble mental—seul problème médical invoqué

VVP: Vlaamse Vereniging voor Psychiatrie (Flemish Psychiatric Association)

For readability, when referring to a person in the singular, the pronouns he, she, and they will be used interchangeably.

Summary

This discussion paper should be taken as the first step in reflection on a subject that is complex and polarizing in terms of values and opinions.

BACKGROUND

Following a court challenge, the criteria for a "natural death [that] has become reasonably foreseeable" in the Canadian statute and for "end of life" in the Quebec statute were declared unconstitutional by the Superior Court of Quebec in September 2019. The withdrawal of these criteria has, *de facto*, opened the door to MAID (medical assistance in dying) for people with chronic conditions, including mental disorders. In the wake of this judgment, the federal Minister of Justice has tabled Bill C-7 to amend the *Criminal Code* (medical assistance in dying). The bill contains a provision that would result in the exclusion of mental illness as an "illness, disease or disability", but does not specify which conditions are included or excluded by the use of the term "mental illness".

The Collège des médecins du Québec (CMQ) and the Commission sur les soins de fin de vie (CSFV) have asked the Association des médecins psychiatres du Québec (AMPQ) to participate in drafting a document that would determine the circumstances in which a person with only a mental disorder as their sole underlying medical condition (MD-SUMC) could access MAID.

This discussion paper therefore seeks to identify the main issues to be taken into consideration when assessing requests and to suggest a method of reasoning in their regard in order to reach the most suitable decision in a given situation.

GUIDING PRINCIPLES

The Quebec *Act respecting end-of-life care* (the "Act") contains certain fundamental commitments that remain important even outside the end-of-life context, particularly that access to MAID is a collective responsibility and is to be administered in exceptional cases. The eligibility criteria must be interpreted in light of the specificity of the mental disorder. These criteria are not based only on facts, but also on a person's values. A request for end-of-life medical assistance is, first and foremost, a request for help from a human being. Moreover, physicians must be aware of their own values, beliefs and life experiences with regard to respect for health, illness, quality of life, and death, and how that could influence their assessment.

The statutory eligibility criteria do not disregard all moral and clinical considerations related to MAID assessments. A capable person cannot be compelled to accept a treatment or intervention, and a physician cannot be forced to administer MAID. Setting up a regime that would allow MAID for persons with MD-SUMC should be accompanied by a commitment from society as a whole to improve access to quality care. The same is true of the health care system, which must be able to offer a variety of therapeutic options for these individuals, particularly for patients whose conditions are difficult to treat, as is done for patients suffering from other health problems. Physicians cannot properly assess a patient's eligibility if the patient has not received or has not had access to appropriate care. **Before becoming eligible for MAID, an individual should have tried all the therapeutic options that are acceptable to him or her.**

Mental disorders: A complex universe with divergent opinions

It is impossible to arrive at a set of rules that will apply in every case. Patients who present with very similar clinical conditions at very similar stages may experience their disease very differently because of various internal factors. These elements combined make for major clinical challenges in assessing a request for MAID for persons with MD-SUMC. **The definition and delineation of the term "mental disorder" will continue to be the subject of fierce and complex debate. The fact of including or excluding certain medical conditions would lock us into a substantive position on what exactly is a mental disorder, which goes beyond the committee's mandate. Consequently, the committee has decided to include all mental disorders listed in the DSM-5 and ICD-11.**

The medical community is not unanimous about the prospect of extending access to MAID to individuals with a mental disorder. A consultation done among Quebec psychiatrists shows that 54% of participants considered that MAID should be allowed for patients capable of consent who were suffering from mental illness, under certain conditions. This figure is similar to the one obtained by the Canadian Medical Association (CMA)

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as part of a survey on the same subject. According to the Quebec psychiatrists who were in favour, additional protection measures should be required for MAID for persons with MD-SUMC compared to MAID in its current form. The treating physician should not be involved in the decision-making process; the assessment process should be more substantive than is required at present. Also, the relational dynamic between the patient, the patient's family and the health care team should be explored in depth.

ELSEWHERE IN THE WORLD

There are five jurisdictions where it is possible to access assistance in dying for a person with an MD-SUMC: Belgium, the Netherlands, Luxembourg, Switzerland and Germany. In these countries, the practice of MAID for persons with MD-SUMC is generally marginal compared to the practice of assistance in dying. Among these countries, Belgium and the Netherlands have developed detailed practice guidelines specific to MD-SUMC.

In Belgium, the substantive eligibility conditions are divided into two groups: individuals who are near death, and others. Three eligibility conditions must apply in the case of MD-SUMC: the individual must be legally capable and conscious at the time of the request, must make a voluntary, informed and repeated request that is not the result of outside pressure, must be in a futile medical situation of constant and unbearable physical or mental suffering that cannot be relieved as a result of a serious and incurable condition caused by an illness or accident. In addition, for patients whose death is not foreseeable, the treating physician must consult two other physicians. The first must give an opinion on the condition that led to the request and identify whether the patient's constant and unbearable suffering cannot be relieved. The second, independent and a psychiatrist in the case of a patient with a mental disorder, must assess whether the constant and unbearable suffering cannot be relieved and certify the voluntary, informed and repeated nature of the request. The Belgian statute also requires a discussion with a multidisciplinary team, if applicable, and with the patient's family, if the patient wishes. A regulatory orientation from the Belgian college of physicians, along with measures and guidelines, round out what is already specified in the statute.

In the Netherlands, the eligibility criteria are the same for all applicants as long as the person's suffering stems from a medical condition, whether or not death is near. In the case of MD-SUMC, these criteria are accompanied by specific prescriptions intended for physicians, along with elaborate and detailed practice guidelines concerning the proper procedures to follow.

MAID AND THE SPECIFICITY OF MENTAL DISORDERS

As in all branches of medicine, there are exceptional situations in psychiatry where even the best care will not treat a mental disorder at a level that would allow the patient to live a life acceptable to him or her. It is clinically impossible to draw up a specific list of mental disorders potentially eligible or not for MAID, for a number of considerations. **As is the case in other fields of medicine, a diagnosis generally does not guarantee a prognosis, and deciding with certainty on the incurability of a disorder is not only very difficult, but often impossible.** In this regard, most of the psychiatrists surveyed considered that eligibility for MAID should not depend on a particular diagnosis. **During an assessment, a number of dimensions need to be covered: the incurable and irreversible nature of a disease, chronicity, treatment efforts, refusal of treatment, suffering, decision-making capacity and suicidal ideation.**

Incurable and irreversible

In strictly medical terms, "incurable" means that it is impossible to reverse, stop or eliminate the underlying patho-physiological process of a disease. However, the underlying patho-physiological processes in most mental disorders are unknown. Mental disorders are instead defined by their symptom profiles, and their treatment usually involves reducing such symptoms. **It would be tempting to say that no action should be taken without a 100% level of certainty. The truth is that uncertainty can exist even in cases of physical illness as well as physical and psychiatric comorbidity. MD-SUMC cases are no exception.**

Chronicity

Chronicity of an illness is an important factor to consider. However, attempting to set a guideline in terms of minimum duration of an illness or psychiatric care would be arbitrary. The duration varies for each case and sometimes can be counted in years. Pharmacological trials may take several months; psychotherapy and rehabilitation programs, up to two or three years. Treatment

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algorithms exist for so-called "refractory" diseases to the effect that modern psychiatry does not consider them to be incurable in the first place. According to a majority of Quebec psychiatrists surveyed, the minimum amount of time living with the disease must be more than five years before a request for MAID for persons with MD-SUMC can be made. Moreover, 42% of those surveyed felt it should be no less than 10 years. **The incurability of a mental disorder could therefore only be determined at the end of a long process, after attempting several treatments and assessing their effects.**

Treatment efforts

In clinical practice, to reach the conclusion of incurability, the psychiatrist must assess the biological, pharmacological, psychological and social interventions already attempted. He or she must take into consideration the exact nature of the treatment or treatments, if they have been properly tested, the reasons for discontinuing treatment, the patient's subjective treatment experience and the relationship with the providers of the treatment. The psychologist must also take into account any other factor that may have altered the effectiveness of a care intervention and ensure that all reasonable alternative treatment solutions were proposed based on the practice guides.

Refusal of treatment

Knowing whether or not an individual requesting MAID for persons with MD-SUMC will be considered incurable and ultimately eligible for MAID will depend on various considerations and the individual's overall clinical condition. **Let us keep in mind that a capable person may refuse a treatment considered by the physician to offer a reasonable prospect of relief from his or her suffering.**

Suffering

Suffering is multifactorial, and mental disorders may impair cognition, emotions, perceptions and judgment, as well as affecting the perception or experience of suffering. The very existence of the criterion of intolerable suffering poses a massive challenge in terms of assessment. For some, suffering is entirely subjective and, as soon as a person states that his or her suffering is unbearable, there is nothing more to be evaluated. Social determinants of health can play a significant role in increasing the suffering, which could even be caused or amplified both by social injustices and the actual mental disorder. **Before deciding on the eligibility of a patient for MAID, the psychiatrist should explore other aspects that shape the patient's life experience and consider strategies to improve the social circumstances that add to the suffering.**

Decision-making capacity

Under Quebec and Canadian laws, a person who requests MAID is required to be capable at the time of the request and during the time it is handled. In Quebec, the requirements for decision-making capacity are defined in regulatory standards rather than by legislation. In its practice guide for MAID, the CMQ suggests that an evaluation of decision-making capacity is first based on the estimation of four cognitive skills: understanding the information, applying the information to the patient's own situation, reasoning based on the information and making one's own choice.

Psychiatric disorders can compromise decision-making for certain people without necessarily affecting their cognitive function. Other factors are involved in decision-making such as mood, values and consistency with the person's identity. **In the context of MAID for persons with MD-SUMC, the assessment of decision-making capacity should be longitudinal and conducted throughout the required clinical meetings and not based on a single meeting. Assessment must go beyond cognitive criteria and take into account emotional reactions, interpersonal dynamics and values resulting from the disorder, which negatively affect the patient's ability to weigh options and make judgments.** Competent evaluators may differ in opinion regarding matters of judgment and decision-making capacity. Although a disagreement does not threaten the legitimacy of the competency assessment process, an insurmountable disagreement could mean that there is too much uncertainty to grant a request for MAID.

Suicidal ideation

A request for MAID for persons with MD-SUMC could be a form of suicide; actually, allowing MAID for persons with MD-SUMC could thwart social prevention efforts. A situation that may seem to be contradictory. **In medicine, including psychiatry, the concept of respect for a person's autonomy sometimes results in accepting decisions that could lead to the person's premature death. Other situations could also lead to major suicide prevention measures, including coercive legal measures, such as institutional custody, if there is a presumption that a**

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person will attempt suicide in the short term. In the three countries where MAID for persons with MD-SUMC is allowed (the Netherlands, Belgium and Switzerland), suicide prevention strategies as well as forensic procedures similar to those in Quebec are designed to protect people with a mental disorder and prevent them from harming themselves. This suggests that such practices should not be considered to be contradictory and that they could coexist.

AN ADAPTED MENTAL HEALTH SOLUTION FOR MAID FOR PERSONS WITH MD-SUMC

MAID for persons with MD-SUMC requires knowledge and expertise in specialties and subspecialties in the treatment of mental disorders. However, access to psychiatric care varies significantly from one region to the next. As a result, certain conditions could be met so that MAID for persons with MD-SUMC can be made available. **Setting up a new clinical administrative entity dedicated to mental health and MAID could ensure appropriate access to psychiatrists and provide coordination, control and prospective monitoring. A MAID regional office—Mental health (MAIDRO—MH) could therefore be set up in each of the integrated university health regions (IUHR).**

Therefore, the MAIDRO-MH could ensure that each request is processed within a specific timeframe, and that procedural consistency is maintained between regions. It could further help identify assessors and providers for each request, ensure that the process is transparent, ensure that a final decision is made and sent to applicants, and finally ensure that documentation related to all requests is retained. The MAIDRO-MH would monitor the assessment process by prospectively reviewing assessment documentation in real time and not *a posteriori*. The monitoring process would ensure that the assessors have properly considered and explained their reasoning concerning eligibility criteria.

Furthermore, the MAIDRO-MH would focus on a number of key points and ensure the independence of the assessors and providers vis-à-vis the treating physician and applicant. The MAIDRO-MH would also ensure that the assessment process is fair; that the eligibility criteria are fully explored and documented; that the assessors take into consideration the dynamics surrounding the request from the MAID applicant as well as social circumstances, and that suicidal ideation, as a symptom of mental disorder, is fully explored. A four-step process would be set up to manage requests for MAID for persons with MD-SUMC. The current assessment procedure for MAID requests in Quebec has been changed to recognize the complexity of assessments in the case of persons with MD-SUMC. Some clinical situations requiring special attention, such as persons with neurodevelopmental disorders and those subject to legal constraints, are also being specifically looked at.

IN SUMMARY

Currently, the eligibility of patients for medical assistance in dying is not based on the diagnosis, but rather on the clinical circumstances specific to each applicant. Patients whose sole underlying medical condition is a mental disorder should not be systematically excluded from MAID on the basis of their diagnoses. Necessary conditions to ensure the rigorous assessment of requests could be put into place in the event MAID for persons with MD-SUMC is allowed. The Association des médecins psychiatres du Québec does not intend to promote MAID MD-SUMC, but recognizes the suffering of patients and their right to make their own choice like any other person. The guidelines, recommendations and solutions proposed in this discussion paper may be enhanced in many ways.

Section 1. Introduction

1.1 BACKGROUND AND RECENT CHRONOLOGY

The Québec Act concerning end-of-life care (AREOLC) was assented to on June 10, 2014, by the Assemblée nationale du Québec and came into force on December 10, 2015 (S-32.0001). It lays out Quebecers' entitlements with respect to end-of-life care, including medical assistance in dying and continuous palliative sedation. While the law was the subject of much debate, it gave Québec society the opportunity to discuss palliative care, advanced care planning, and end-of-life care.

The Supreme Court of Canada's decision in the case of Carter v. Canada, released on February 6, 2015, invalidated the Criminal Code prohibition against anyone who "aids or abets a person in committing suicide" or anyone "who may consent to death being inflicted on them" 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 (*Carter v. Attorney General of Canada*, [2015] 1 R.C.S. 331). Following this decision, on June 17, 2016, the federal government enacted the Act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying) (S.C. 2016, c. 3), authorizing MAID and assisted suicide. Although medically assisted suicide is non-criminal, it is excluded by the Québec law and is rarely practised in Québec.[1] Both laws being valid, they apply to Québec even though, clinically, Québec physicians practise according to the AREOLC. This document will therefore focus on MAID as defined in the AREOLC.

The eligibility criteria to receive medical assistance in dying are:

Québec (An Act Respecting End-of-life Care)

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 (Ch. A-29);
2. Be of full age and capable of giving consent to care;
3. Be at the end of life;
4. Suffers from a serious and incurable illness;
5. Be in an advanced state of irreversible decline in capability;
6. Experiences constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

One of Canada's eligibility criteria is that the person "suffers from a grievous and irremediable medical condition," an expression found in the *Carter* decision. This expression was defined in the federal law by four components, which are very similar to the four clinical criteria (criteria 3–6) found in the Québec law, except that instead of the person being at the "end of life," her "natural death" must have "become reasonably foreseeable."

Canada (An Act to Amend the Criminal Code and to make related amendments to other Acts [medical assistance in dying])

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;
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;
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.

[1] Assisted suicide or self-administered MAID, in which a person ingests substances prescribed by a physician on a date and time of their choosing, is rarely practiced in Canada as well.

241.2 (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;

d) Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without prognosis necessarily having been made as to the specific length of time that they have remaining.

Not long after both laws came into force, lawsuits were initiated challenging their constitutionality. In British Columbia, Julia Lamb contested the inclusion of "natural death reasonably foreseeable" found in the definition of a "grievous and irremediable medical condition" in Canada's law. Despite the fact that she was affected by a degenerative condition, the timing and cause of her natural death were not foreseeable. In September 2019, Canada's medical expert provided the opinion that if Ms. Lamb expressed the certain intention to cease her BiPAP (bilevel positive airway pressure) machine, which she required to breathe, and to refuse treatment for an inevitable pneumonia, her natural death would be reasonably foreseeable at the time of these refusals. Given that Canada already considered, Ms. Lamb to be eligible upon the refusal of BiPAP and pneumonia treatment, the case was adjourned (Downie 2019).

In Québec, Jean Truchon and Nicole Gladu, two persons with physical disabilities but no active mental disorder, also challenged the criteria "natural death has become reasonably foreseeable" and "end of life." On September 11, 2019, the Québec Superior Court found that these criteria violated certain rights guaranteed under the Canadian Charter of Rights and Freedoms (*Truchon c. Procureur général du Canada*, [2019] QCCS 3792). The Court suspended its decision for six months until March 11, 2020, and both the Québec and Canadian governments stated that they would not appeal the Court's decision (*Globe and Mail* 2019; Harris 2020). As a result, the criterion "end of life" was no longer in effect. However, on March 2, 2020, the Québec Superior Court granted a four-month extension at Canada's request (*Truchon v. Canada [Attorney General]*, [2020] QCCS 2019). Because of the coronavirus pandemic, at the end of June 2020, Canada requested and was granted an additional five-month extension until December 18, 2020 (*Truchon c. Procureur général du Canada*,[2020] QCCS 2019). During the suspension period, people in Québec considered eligible for MAID by two physicians have been entitled to seek a judicial authorization in order to have access. To date, five authorizations have been given in Québec, none for a case involving MD-SUMC (*Payette c. Procureur général du Canada*, [2020] QCCS 1604 ; *C.V. et Trudel*, [2020] QCCS 1717; *Trudeau c. Procureur général du Canada*, 2020 QCCS 1863; *Lessard et Procureur général du Canada*, 2020 QCCS 3189; *Sinclair et Procureur général du Canada*, [2020] QCCS 3196).

While persons with mental disorders are not explicitly excluded from accessing MAID either by Québec's or Canada's laws, the eligibility criteria of "end of life" (Québec) and "natural death reasonably foreseeable" (Canada) make it unlikely for most of such persons to be eligible. It is the removal of these criteria that opens the door to persons with chronic conditions, including chronic mental disorders, to seek MAID. Thus, in January 2020, the Collège des médecins du Québec (CMQ) and the Commission sur les soins de fin de vie (CSFV) asked the Association des médecins psychiatres du Québec (AMPQ) to participate in the development of practice recommendations for those circumstances in which a person for whom a mental disorder was the sole underlying medical condition (MD- SUMC) had requested MAID. The Board appointed a committee which held its first meeting on February 4, 2020.

On February 24, 2020, Canada introduced Bill C-7—an Act to amend the Criminal Code (medical assistance in dying)—containing new safeguards for persons whose natural death was not reasonably foreseeable. The bill contains a clause which excludes mental illness[2] from being considered as an illness, disease or disability for purposes of the requirement that a person must have a serious and incurable medical condition. Which conditions are included and excluded by the expression "mental illness" is not explained. The bill also states that further consultation and deliberation on the matter of MAID MD-SUMC are required and, in fact, the original federal law stipulated that such a review be undertaken

[2] As we explain below, standard terminology within psychiatry is "mental disorder" rather than "mental illness." Therefore, it is uncertain whether the bill's use of "mental illness" is intended to refer to a subgroup of mental disorders or whether it is a synonym of "mental disorder."

As is the case for all others, we think that it is a person's clinical circumstances and not his diagnosis that should determine MAID eligibility.

Patients whose sole underlying medical condition is a mental disorder or mental illness should not be systematically excluded from accessing MAID.

as of June 17, 2020. Following the introduction of C-7, the CMQ advised its members not to assess a request for MAID MD-SUMC while the bill was under study (CMQ et al. 2020). The bill died on the order papers due to the prorogation of the parliament of Canada in August 2020 but was presented again on October 5, 2020 (Bill C-7).

At this point, we do not know if this bill will be voted into law. However, even if it becomes law and the exclusion clause takes effect, we, as psychiatrists, are aware that patients do not necessarily fit neatly into categories of physical disease or mental disorder (or "mental illness" in the language of the bill). Many patients are affected by both types of conditions or complex conditions with both psychiatric and non-psychiatric components. And contrary to what is implied in the bill, people's reasons for requesting assisted dying are not easily separable into those caused by physical versus psychiatric disease. Indeed, cases of complex comorbidity have existed since MAID has been practised in Québec and raise the same challenging questions as do cases of MD-SUMC, including those of decision-making capacity, suicidality, incurability, and the impact of the social determinants of health on suffering. Excluding persons whose requests for MAID are based solely on a mental disorder will not eliminate complex cases or even the most complex cases. Thus, we consider it timely, regardless of the fate of bill C-7, to reflect on these issues.

1.2 BASIC POSITION

It is important to note from the outset that persons whose mental disorder is their sole underlying medical condition have never been excluded from either the Canadian or Québec laws nor have been those with conditions having both mental and physical components and those with coexisting physical and mental conditions, even if the request for MAID is motivated primarily by the mental disorder. In fact, the eligibility criteria for neither law is not based on a person's diagnosis but rather on the entirety of her clinical circumstances.

It is therefore more appropriate to ask whether persons with MD-SUMC can find themselves in the clinical circumstances reflected in the eligibility criteria of both laws. There has been a great deal of debate on this point (The Halifax Group 2020, 20; Expert advisory group on medical aid in dying 2020, 6). Some argue that mental disorders can never fulfill the criterion of "grievous and irremediable medical condition/serious and incurable disease."[3] Others have questioned whether the tools we have to detect such cases in practice (for example, capacity assessment) are adequate to distinguish between those who fulfill the criteria and those who do not (Council of Canadian Academies 2018, 68). Still others wonder whether the very fact of making a request for MAID reflects suicidal thinking (Council of Canadian Academies 2018, 62), a phenomenon associated with several mental disorders.

In reflecting on these debates, the question arises: are there characteristics specific to all people with mental disorders or mental illnesses that distinguish this group of people from other groups who are not excluded? Numerous colleagues have called for empirical research on a variety of themes related to this question (see, for example, Nicolini et al. 2020; van Veen et al. 2020; Sinyor and Schaffer 2020). We agree that there are many important questions worthy of research that will inform and refine the ongoing debate. However, whether to permit MAID MD-SUMC is not an empirical question, it is an ethical one. Empirical research can help to support ethical arguments but cannot replace the necessary moral deliberation. The debate about MAID at the end of life illustrates this point. Even with much greater empirical knowledge about the incurability and the decline involved in the types of conditions that motivate MAID requests at the end of life (end-stage cancer in the majority of cases) (Commission sur les soins de fin de vie, 2019, 14), there has been extensive debate about whether MAID is ethically permissible (Commission spéciale sur la question de mourir dans la dignité 2012, 53-77 ; *Carter v. Canada* (Attorney General), 2012 BCSC 886., 2012, 55-81).

As is the case for all others, we think that it is a person's clinical circumstances and not his diagnosis that should determine MAID eligibility. Patients whose sole

[3] See, for example, Elkouri 2020. Two arguments are offered. Either there is always a possibility of relief of suffering when one suffers from a mental disorder or a person's suffering is always due to societal-level failures to address determinants of health and not due to the mental disorder.
See also: https://www.eagmaid.org/report. Here we find the argument that it is never possible to determine that a mental disorder is irremediable or that the decline in capacity is irreversible.

underlying medical condition is a mental disorder or mental illness should not be systematically excluded from accessing MAID.

The idea that it is impossible in all cases to fulfill the existing legal eligibility criteria is not plausible on clinical grounds. Although rare, clinical experience indicates that there are some persons who have had excellent care over a prolonged period of time who continue to suffer terribly and whose quality of life is unacceptable to them (Kious and Battin 2019, 34).

Given that MAID can already be provided to those with comorbid physical and psychiatric disorders and those with conditions having both physical and mental components, the argument that we can never make judgments about the eligibility criteria using our existing methods for people with mental disorders as their sole underlying condition does not withstand logical scrutiny.

And the idea that MAID can never be a last therapeutic avenue to alleviate the suffering of a person with a severe, chronic mental disorder is unpersuasive given that following the Truchon-Gladu decision, it can be acceptable in some cases for those with chronic physical disorders (with or without psychiatric comorbidity) even if the person is not at the end of life or her natural death has become reasonably foreseeable. Therefore, in certain exceptional clinical situations, providing MAID MD-SUMC is ethically permissible. The social policy that should follow from this, however, is a question for the legislator.

This document is intended to provide practical guidance to any clinician who receives a request for MAID MD-SUMC.[4]

In this document, we have chosen to use the expression "mental disorder" as it is this expression that is used by standard classification schemes such as the *DSM-5* and the *ICD-11*. The definition and demarcation of the term "mental disorder" has been and continues to be the subject of vigorous and complex debate. Choosing certain conditions to include or exclude would force us to adopt a substantive position on what counts as a mental disorder, a question that is well beyond the scope of this document.[5] Thus, the committee concluded that it had no choice but to include all mental disorders as identified by the *DSM-5* and the *ICD-11*.

Given that MAID can already be provided to those with comorbid physical and psychiatric disorders and those with conditions having both physical and mental components, the argument that we can never make judgments about the eligibility criteria using our existing methods for people with mental disorders as their sole underlying condition does not withstand logical scrutiny.

[4] The mandate of our committee was to consider MAID MD-SUMC. However, we do not believe that the issues we discuss concerning this group of persons apply only to them. The complexity in assessing MAID requests from this group may also arise for those with certain types of physical conditions and those with comorbid MD and non-MD where MD is the primary motivation.

[5] We note that specific terms can be used to separate categories of conditions; for example, the World Health Organization employs "cognitive disability" to specify persons with dementia (WHO 2019, xxv). Whether certain categories of conditions should be considered MD-SUMC is a question of social policy.

SECTION 1. INTRODUCTION

it is not possible to provide a set of rules and interpretations that will apply in every case.

A survey conducted by the AMPQ showed that among Québec psychiatrists, 54% of the 263 respondents[6] were open to MAID MD-SUMC at least in some circumstances while 36% were opposed in all situations (AMPQ 2020). Respondents added comments to the effect that if it were to be practised, additional safeguards should be required for MAID MD-SUMC compared to MAID in its current form. Among these were that the treating physician should not be involved in the decision-making process, the assessment process should be more substantial than what is currently required, there should be a minimal duration of active treatment (years) and a minimal duration of experience with the condition (years), and, finally, the relational dynamics between the patient, his significant others, and the treating team should be carefully explored.

This document proposes a process that takes into account the major clinical challenges involved in assessing a MAID MD-SUMC request as identified in the literature and by experts in the field. That said, it is not possible to provide a set of rules and interpretations that will apply in every case. Patients with very similar clinical conditions at similar stages may have different experiences of illness depending on a variety of factors both internal and external to them. Our intention is to identify the central issues that should be considered in such assessments and a way of reasoning about them in order to arrive at a decision that best suits the individual's situation.

This document gives voice to the uncertainties and values that must be considered in assessing such a request and incorporates several of the protective measures recommended by our colleagues in the AMPQ survey. We also propose a new administrative structure whose role is to ensure access to appropriate assessment and care to those who request MAID, procedural consistency throughout the province, and prospective guidance and oversight to all those involved.

This structure and the process we recommend concern MAID MD-SUMC because this was our mandate. However, we believe this process, or a version of it, can be applied to any complex clinical situations outside the end of life that raise the same difficult questions as MAID MD-SUMC.

[6] This reflects a response rate of approximately 21%.

1.3 GUIDING PRINCIPLES

The following principles frame the subsequent recommendations.

1. A request for medical assistance in dying is, above all, a request for help from a fellow human being.

The attitude of the physician who receives a request must be one that exemplifies a caring and well-meaning human relationship. The process of exploring a request ought to be therapeutic from beginning to end. No physician is required to be involved in the process of evaluating requests for MAID nor providing MAID but in all cases, the physician should take the request seriously, refer the patient appropriately and, when possible, remain involved in her usual clinical role.

2. The AREOLC contains certain foundational commitments that remain important even outside the end-of-life context.

These include:

1. That the provision of MAID is a collective responsibility of the healthcare system and the medical profession.
2. That MAID should be considered an option only in exceptional circumstances.
3. With the agreement of the requester, the network of which the person is a part (healthcare team and significant others) ought to be involved in the assessment process.

3. The eligibility criteria need to be interpreted in light of the specificity of mental disorders.

The AREOLC focused on MAID for the person facing the end of their life. In this context, the expressions "serious and incurable disease" and "advanced state of irreversible decline in capability" (two of the remaining five eligibility criteria in Québec) have specific meanings. Outside of the end of life, these expressions need to be interpreted considering the specificity of mental disorders. For example, "advanced state of irreversible decline in capability" at the end of life is often understood in physical terms: mobility, sensory capacity, excretory functions. In the context of mental disorder, "decline in capability" should be interpreted in light of those spheres of function affected by mental disorders: thinking, feeling, and behaving.

4. The eligibility criteria are not only questions of fact but of value.

Physicians will have to provide an opinion about several challenging questions when assessing persons who request MAID MD-SUMC. These include decisional capacity, incurability, advanced and irreversible decline, and whether or not the person who requests MAID is harmful to himself in the meaning of the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others* (P-38.001). These are not only questions of fact but also of values[7] (e.g. How much decline is enough decline to be considered advanced? When is suffering intolerable?). While it is possible for assessors to apply a consistent and thorough method across different cases, it is not possible to create an assessment process that is objective in the sense of being value-free. Physicians should strive to elucidate the patient's values and vision of a good life as the starting point of the assessment. Nevertheless, qualified and competent physicians can disagree about both the interpretation of facts and the weight to accord values. As a result, we should expect that at times there will be divergences between physicians in the outcome of MAID assessments. Divergence in and of itself does not invalidate the process.

5. Physicians should strive to be aware of their own beliefs, values, and experiences with respect to health, disease, quality of life, and death.

Because MAID assessments necessarily draw upon individual judgment, physicians who assess requests and provide MAID should be aware of their own beliefs, values and experiences, and how these factors affect their judgment. Assessors cannot eliminate their subjectivity from the assessment process, but they can be attentive to whether, when and how it might unduly influence their opinion about a person's eligibility. For example, a painful personal experience with death in one's family might influence the physician's assessment of a request. Physicians who choose not to participate in MAID should also be aware of their beliefs, values and experiences with respect to health, disease, quality of life, and death as they may continue to be the treating physicians and the trusted resource people for patients who are undergoing the process of making a request, even if they are not themselves involved in the process.

[7] Here we refer to the shared values of the medical profession, not the values of any individual physician. In her 2016 book, *L'aide médicale à mourir au Québec: pourquoi tant de prudence (Medical Assistance in Dying in Québec: why so prudent)*, Michèle Marchand considers the physician to be a moral agent at three levels: as an individual, as a member of a profession, and as a member of a collective. A physician who is assessing a person for MAID must inevitably draw upon values in doing the assessment and these ought to be the values of the profession. The physician should try to be aware of her personal values and ensure that these do not exercise undue influence upon her clinical judgment.

6. The statutory eligibility criteria do not exhaust all of the morally and clinically relevant considerations for MAID assessments.

The criteria provide the minimum legal requirements that must be fulfilled in order to receive medically assisted dying. However, ethically and clinically sound medical care requires more than can be captured in the text of a law. Indeed, the federal law is clear that MAID ought to be provided "…with reasonable knowledge, care and skill, and in accordance with any applicable provincial laws, rules or standards." This statement creates room for professional organizations and regulatory authorities to develop clinical standards for MAID assessment and provision appropriate to the populations they serve and the contexts in which they work. We believe it is crucial for clinicians working in the field of mental health to play an important role in determining how the eligibility criteria should be applied in light of the specificity of mental disorders, as well as in developing processes to facilitate assessments sensitive to the needs of their patients.

7. A capable person cannot be required to accept a treatment or intervention and a physician cannot be required to provide MAID.

The Civil Code of Québec (articles 11-14) permits all capable persons aged 14 and over to make decisions about healthcare interventions.[8] A capable person requesting MAID can refuse any intervention proposed by a physician who is assessing him. However, if a person refuses an intervention that an assessing physician believes will have a reasonable chance of improving his condition, the physician may not be able to form an opinion that he fulfills certain eligibility criteria (particularly incurability and advanced state of irreversible decline) and therefore may decide not to provide MAID. A person's refusal of other options does not automatically make MAID the only available option nor does it require the physician to provide it.

8. Patients with mental disorders need timely access to appropriate care. People with difficult-to-treat mental disorders are entitled to have access to new and promising treatments.

The problem of ensuring adequate access to appropriate care to patients with mental disorders is a perennial one. Establishing a regime that permits MAID MD-SUMC must be accompanied by a societal and health-system commitment to providing therapeutic options to these persons, particularly those with difficult-to-treat conditions, just as we do for patients with other kinds of conditions. Physicians will not be able to properly assess whether a person is eligible if she has not been offered appropriate care and if it is left to individual clinicians and patients to secure access to appropriate care. However, this should not be taken to mean that a person must be provided with or have tried every existing therapeutic option in order to be eligible.

[8] Both the Canadian and Québec laws require that a person be 18 or over to request MAID.

Section 2. International practice standards

2.1 MAID MD-SUMC AROUND THE WORLD

In this section we look at other countries in which assistance in dying is permitted in cases of MD-SUMC. We must exercise caution about drawing straightforward comparisons between countries with different cultural contexts and healthcare systems. However, the systems in place in other countries demonstrate current approaches to assisted dying of persons with MD-SUMC and their experiences can also alert us to subjects of enduring debate. The goal of this section is not to undertake a comparison of the eligibility criteria between Québec and these countries but, rather, to examine what professional and regulatory organizations consider to be good clinical practice for MAID MD-SUMC.

There are five jurisdictions in the world which allow assisted dying for MD-SUMC.[9] They are Belgium, the Netherlands, Luxembourg, Switzerland and Germany. In these countries, the practice is infrequent relative to the practice of assisted dying in general. In the Netherlands, when one considers all types of requesters, just under half of all requests for euthanasia and assisted suicide are carried out. The remaining requests are refused, withdrawn, or the person dies before euthanasia is approved or between when it is approved and carried out (Jansen-van der Weide et al. 2005). In 2016, 60 of the 6091 cases of euthanasia were for persons whose psychiatric disorder was a primary motivating factor, while approximately 1100 requests were made by such persons. In the Netherlands in 2016, just under 1%[10] of all euthanasia cases carried out were for persons whose psychiatric disorder was the primary motivating factor. These 60 cases represented 5% of all the requests made for MAID by patients with psychiatric disorders as their motivating factor. In a case series of 100 consecutive referrals for euthanasia for psychiatric disorder in Belgium, 48 cases were found eligible and 35 were carried out (Thienpont et al. 2015). Eight of those considered eligible withdrew their requests because they changed their minds. Two of those found eligible committed suicide prior to euthanasia while four of those who had been refused committed suicide.

Among these countries, Luxembourg has not yet recorded a case of this type and its professional practice guidance is general, covering all types of cases (Commission nationale de contrôle et d'évaluation 2019, 13; Council of Canadian Academies 2018, 120). The Swiss approach is not based on a person having a medical condition; therefore there is no specific guidance regarding mental disorders (Council of Canadian Academies 2018, 115). Instead, there are norms held by assisted dying associations for their practices and guidelines published by medical and scientific organizations that structure the practice for all persons who request assisted dying (Council of Canadian Academies 2018, 118). The German situation is in transition, with a court decision permitting assisted suicide in February 2020 (BBC 2020). Thus, we turn to the Netherlands and Belgium, which have both developed detailed practice guiding documents specific to MD-SUMC.

[9] Here we exclude Canada and Québec, where the practice is legally permissible but the eligibility criteria largely exclude those with mental disorders.

[10] If we include dementia, this figure rises to approximately 3%.

SECTION 2. INTERNATIONAL PRACTICE STANDARDS

The table below summarizes the primary resources[11] in both countries and those we have consulted in depth.

ORGANIZATION	TYPE OF DOCUMENT	YEAR PUBLISHED
NETHERLANDS		
Dutch Psychiatric Association (NVvP)	Practice Guidelines	2018
Regional Euthanasia Review Committees (RTE)	Euthanasia Code	2018
BELGIUM		
College of Physicians	Regulatory Guidance	2019
Flemish Psychiatric Association (VVP)	Advisory Document	2017
Ethics Advisory Committee of Belgium	Advisory Document	2017

The legal frameworks of these two countries differ slightly. The Netherlands does not include an eligibility criterion concerning the person's proximity to death. Thus, the eligibility criteria are the same for all requesters as long as the person's suffering arises from a medical condition. The Belgian eligibility criteria create two different groups: those who are close to death and those who are not. Following the Truchon-Gladu decision, Québec is in a legal situation similar to the Netherlands where the eligibility criteria are the same for all requesters as long as the person's suffering arises from a medical condition, whether or not death is proximate. However, the new federal bill adopts an approach similar to Belgium's by separating requesters into two groups: those whose natural death is reasonably foreseeable and those whose natural death is not reasonably foreseeable. Because of the mental illness exclusion, those with MD-SUMC would not fall into either group.[12] And those with comorbid psychiatric and medical conditions would fall into either group depending on whether their natural death is considered to be reasonably foreseeable.

2.2 DUTCH DUE CARE CRITERIA

A physician who provides assistance in dying to a person who requests it is not criminally liable if she follows the due care criteria. These criteria apply to all requesters, including those with mental disorders.

The physician must

a) be satisfied that the patient's request is voluntary and well considered;

b) be satisfied that the patient's suffering is unbearable, with no prospect of improvement;

c) have informed the patient about his situation and his prognosis;

d) have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;

e) have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;

f) have exercised due to medical care and attention in terminating the patient's life or assisting in his suicide (RTE 2018, 8).

Note that while an independent consultation is required, agreement between the two physicians is not.

[11] Other organizations have also published recommendations and advisory documents (Verhofstadt et al 2019). We focused on those with a national scope.

[12] This assumes that mental illness is a synonym for mental disorder.

SECTION 2. INTERNATIONAL PRACTICE STANDARDS

Two documents provide specific additional guidance. The first is the Code of Practice that has been published by the Regional Review Committees. These committees provide retrospective oversight of all reported cases of euthanasia and assisted suicide[13] (EAS) and are empowered to refer non-compliant cases to the legal system. Through their experience reviewing cases considered to be compliant and non-compliant, they have drafted suggestions for practitioners from a regulatory point of view.

The RTE makes certain specific suggestions for cases of MD-SUMC:

1. Physicians should exercise great caution particularly with respect to the notions of the voluntary and well-considered nature of the request, the absence of any prospect of improvement, and the lack of a reasonable alternative.
2. The complexity of the clinical problems often found in such cases requires the expertise of a psychiatrist.
3. Before the independent physician is consulted concerning criteria a) through d), an independent psychiatrist with expertise in the conditions(s) motivating the demand ought to be consulted. This person must assess whether there are or are not reasonable alternatives to try (which may include diagnostic considerations) and propose a treatment plan if necessary. The psychiatrist may also assess the voluntariness of the request.
4. Such practices may also be necessary for patients with comorbid somatic and psychiatric problems.
5. Physicians should consult the guidance of the Dutch Psychiatric Association (NVvP) (RTE 2018, 6).

For its part, the NVvP provides extensive and detailed practice guidelines to practitioners regarding the appropriate procedures to follow. Some of this advice is similar to what the RTE recommends. Certain suggestions are interpretive of the due care criteria, while other suggestions concern best practices that are not covered by the criteria.

Best practices include:

1. Maintaining openness with one's patients regarding the topic of death and dying, even if ultimately the treating physician will not be involved in the request.
2. Being aware of one's own values, beliefs and experiences and the impact these could have on maintaining an open dialogue with the patient. This includes awareness of transference and countertransference (in the technical sense) and seeking out resources such as supervision to monitor it.
3. Informing the person about the length of time the whole process can take (and ensuring adequate time is allocated to the process).
4. Being attentive to not creating false expectations in the patient.
5. Assessing acute suicidality.
6. Assessing voluntariness of decision-making, taking into consideration that, in some cases, the mental disorder itself undermines the voluntariness of a person's decision-making.
7. Involvement of the multidisciplinary team in the assessment.
8. Involvement of the family in the assessment (unless this is refused by the patient or is contraindicated) (Dutch Psychiatric Association 2018, 36–40).

The role of the independent psychiatrist is to help the treating/responsible physician by providing expert advice as to further treatment options for the person requesting EAS. It is the independent physician's role to provide a second opinion about EAS as such. The NVvP recommends that the independent physician be a psychiatrist if the first physician is not. The RTE does allow one physician to fulfill the role of both the independent psychiatrist and the independent consultant in situations where it is "burdensome" for the patient to have three separate consultations. However, all of the required tasks, including the proposal of a treatment plan if appropriate, as well as an opinion on criteria a) through d), must be completed.

[13] This is the expression used for assisted dying in the Netherlands.

2.3 BELGIAN ELIGIBILITY CRITERIA (SUBSTANTIVE CRITERIA)

In Belgium, euthanasia for psychological suffering is allowed if the patient:

1. is a legally competent person of age or a legally competent emancipated minor who is conscious at the moment of the euthanasia request;
2. has made a voluntary, well considered, and repeated request that is not the result of any external pressure; and
3. is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable condition caused by illness or accident (The Constitutional Court of Belgium, 2015).

For all patients whose death is not foreseeable, the attending physician must consult two physicians. The role of the second physician is to give an opinion about the medical condition motivating the request and to ascertain the patient's constant and unbearable suffering that cannot be alleviated. This physician must be considered competent to do so. The third physician must also be independent and in the case of a requester with a mental disorder, he must be a psychiatrist, who must ascertain the constant and unbearable suffering that cannot be alleviated and the voluntary, well considered, and repeated nature of the euthanasia request. The Belgian law also requires discussion with the multidisciplinary team when there is such a team involved, as well as with the family if the person wishes.

The Ordre des médecins offers regulatory guidance whose purpose is to complete what is in the law. This guidance is based on input from the Flemish Psychiatric Association (VVP) and its French-speaking counterpart, the Société royale de médecine mentale de Belgique (SRMMB).

The Ordre recommends several additional measures:

1. That both independent consultants are psychiatrists.
2. That there should be a group discussion involving all three in which each presents their point of view. The goal is to draft a report together with a shared conclusion, although they are not required to agree on every point. The meeting should include other professionals involved in the person's care.
3. While the law lays out expectations that the first assessment takes place over the course of several conversations separated in time and that at least one month must elapse between the receipt of the written request and euthanasia itself, the Ordre makes clear that a lengthy period of clinical follow-up is required to establish that a request is repeated.
4. A patient who refuses evidence-based treatments cannot be considered to be incurable and, therefore, the practitioner cannot provide euthanasia. However, in such cases the treatment being proposed (and refused) must be likely to relieve the person's suffering. (Conseil national, Ordre des médecins, 2019)

The VVP has developed detailed practice guidance based on the NVvP practice guidelines and largely supports the advice contained within them. The VVP states clearly that in cases of MD-SUMC, the evaluation process must go beyond what is legally required and include the following elements:

1. At least two of the three physicians involved should be psychiatrists.
2. Both consultants examine all of the statutory criteria and do not merely fulfill the tasks that are assigned to them by the law. At least one of the psychiatrists involved should explore the meaning of the request, as well as the underlying inter- and intra-personal dynamics involved.
3. At least two of the three physicians involved must agree that EAS can be provided.
4. Patients should allow contact with previous providers involved in their case and that refusal to do so may be sufficient to refuse a request.
5. All involved adopt the attitude of the "twin track" in which a request for euthanasia is both explored and taken seriously but the pursuit of recovery, improved quality of life and relief of suffering continues.
6. The VVP states that if a person refuses a treatment offering a reasonable prospect of success, the legal criterion of incurability is not fulfilled (VVP 2017).

In September 2017, the Ethics Advisory Committee of Belgium prepared a position on euthanasia in relation to psychological suffering and in relation to MD-SUMC. The committee was tasked with providing ethical analysis rather than practice guidance. However, its deliberations revealed divergent viewpoints on whether or not MD-SUMC should be treated as it is currently under the Belgian law, whether the law should be modified to be stricter and more specific for mental disorders, or whether it should be modified to exclude psychiatric disorders altogether (Comité consultatif de Bioéthique de Belgique 2017, 63).

2.4 SPECIAL RESOURCES

Both the Netherlands and Belgium have special resources within their countries to facilitate careful practice of EAS. The Royal Dutch Medical Association (KNMG) has developed a specialized training program in EAS for physicians and created a network of these doctors known as SCEN (Support and Consultation on Euthanasia in the Netherlands) physicians. SCEN physicians often act as the independent consultant in EAS cases, although this is not a legal requirement. They are also available for informal consultation.

An organization called Expertisecentrum Euthanasie (formerly End of Life Clinic) was established in 2012 by the Dutch Association for the Voluntary End of Life (NVVE) and financed by private donation. The organization is a network of clinicians who conduct euthanasia evaluations for persons whose physicians do not want to be involved in EAS or who have refused their requests. The organization operates mobile services in different communities. This group is increasingly involved in cases involving mental disorders. For example, in 2016, it was involved in 75% (46 of 60) of euthanasia and assisted-suicide cases involving persons with MD-SUMC (Council of Canadian Academies 2018, 127).

In Belgium, the Life-End Information Forum (LEIF) was founded by individuals involved in end-of-life care. The organization, financed by the government, has a network of physicians who can provide independent consultation for EAS cases. It also offers information and advice to patients, families and providers about end-of-life care.

2.5 SUICIDE AND SUICIDE PREVENTION

Although not specific to MAID MD-SUMC, clinical situations can arise in which a person who makes a request for assistance in dying may have been suicidal in the past, expresses suicidal thoughts or intentions or makes a suicide attempt during the evaluation process, or expresses suicidal intent if they are refused assistance in dying.

Both the NVvP and the VVP recommend that clinicians make a distinction between acute and chronic suicidality. Acute states of suicidality should be handled in the usual manner: from using the therapeutic relationship to relieve distress all the way to coercive measures such as involuntary hospitalization to ensure personal safety. The Dutch guidelines explicitly tackle the question of chronic suicidal thinking in persons with mental disorders. They state that the apparent distinction between chronic suicidality and a request for assisted dying can disappear in those cases where a person is able to make a reasoned decision about their condition. However, they call for special attention in situations where a person makes what seems to be a request for euthanasia in the context of a self-destructive, borderline (in the technical sense) relational dynamic (NVvP 2018, 39).

This latter advice highlights the complexity of this issue and supports the NVvP's view that psychiatric input is required for such cases.

Section 3.
MAID and the specificity of mental disorders

It is tempting to say that there is no distinction between mental disorders and other types of illnesses. It is increasingly understood that mental disorders affect the body's physical functioning and that one's mental state influences one's pain and suffering. Similarly, physical illnesses have an important impact on a person's mental state. The interaction between the brain and the endocrinologic, digestive, immunologic, respiratory, and reproductive systems can affect feeling, thinking, and behaviour. We could argue that mental disorders should be assessed in the same manner as other disorders when it comes to requests for MAID.

Indeed, this position could contribute towards countering the discrimination that continues to exist against those with mental disorders. Such a position recognizes that the suffering of these patients is as important as that brought about by other disorders. Furthermore, it implies that these patients are equally entitled to exercise their self-determination. These are laudable premises. Nevertheless, even while affirming that persons with mental disorders are entitled to the same access to MAID as persons with physical diseases, a MAID assessment for a patient whose mental disorder is the sole underlying medical condition requires certain specificity.

Mental disorders can affect one's understanding of one's condition, capacity to make medical decisions, self-evaluation of suffering, and hope for the future. This is why it is crucial for physicians to be a source of hope as patients themselves may lose this capacity. Maintaining hope is a key ingredient in recovery. Receiving a request for MAID from a patient may induce a feeling of failure in the physician. As a result, the physician may find it difficult to change therapeutic strategies from the pursuit of recovery towards the relief of suffering.

In all areas of medicine, there are exceptional situations in which even the best psychiatric care will not succeed in treating a mental disorder sufficiently to enable a person to live what they consider to be an acceptable life.

Nevertheless, as in all areas of medicine, there are exceptional situations in which even the best psychiatric care will not succeed in treating a mental disorder sufficiently to enable a person to live what they consider to be an acceptable life. In such a situation, a person may wish to discuss the possibility of MAID. While simultaneously maintaining an attitude of hope, the psychiatrist should offer to discuss and explore the person's understanding of and perspective about MAID. A psychiatrist who conscientiously objects to MAID should explain this to the patient while remaining open to discussing other topics, even painful ones, as is the case in usual clinical practice.

Some might like us to draw up a list of those mental disorders which could be eligible for MAID. Clinically, this is impossible for several reasons. As is the case in other areas of medicine, a diagnosis in and of itself does not guarantee prognosis. Similarly, being certain about the incurability of a disorder is very difficult, often impossible. Incidentally, according to the AMPQ survey of its members, 64% of respondents agreed that MAID eligibility should not depend on a specific diagnosis but, instead, that any mental disorder could be potentially eligible (AMPQ 2020).

In strictly medical terms, "incurable" refers to the reversal, halting, or elimination of an underlying pathophysiological process of a disease. The underlying pathophysiological processes involved in most mental disorders are unknown. Instead, mental disorders are defined by their symptom profiles and treating disorders usually involves symptom reduction.

The chronicity of a disorder is an important factor to consider. However, any specific time requirement for the minimal duration of experience of illness or of psychiatric follow-up would be arbitrary.

SECTION 3. MAID AND THE SPECIFICITY OF MENTAL DISORDERS

In this section we address:

1. when a mental disorder could be considered a serious and incurable "illness, disease, or disability" characterized by an "advanced decline in one's capacity";
2. how to understand and assess a person's suffering;
3. when and how a mental disorder can affect capacity; and
4. how to distinguish between a desire to die that is the symptom of a mental disorder versus a request for MAID.

These are, in fact, the issues that the expert panel of the Council of Canadian Academies identified in its report on the state of knowledge concerning MAID MD-SUMC (2018, 62).

Out of necessity, the eligibility criteria are discussed one at a time below, but it is important to remember that a grievous and irremediable medical condition is defined by all sub-criteria taken together. Similarly, a person who requests MAID in Québec must fulfill all the criteria as a whole. The criteria paint a portrait of a set of clinical circumstances to which MAID may be an appropriate response.

3.1 INCURABLE AND IRREVERSIBLE

Clinically, outside of the end-of-life context, our capacity to predict the future becomes more difficult. It is not surprising that when considering mental disorders, the most controversial aspects of the legal definition of a grievous and irremediable medical condition are the concepts of "incurable" disease and "irreversible" decline.

It is possible that a person who has recourse to MAID—regardless of his condition—could have regained the desire to live at some point in the future. It is also possible that new interventions may emerge that could have modified the person's clinical state sufficiently to reduce his suffering. Once MAID is permitted outside the end of life, this uncertainty cannot be eliminated. Thus, the question becomes: how certain must an assessor be in order to find someone eligible for MAID MD-SUMC? Assessors will have to answer this ethical question[14] each and every time they evaluate a request. It is tempting to say that we should not act unless we are 100% certain. But once the criterion "natural death reasonably foreseeable" is no longer required, this uncertainty can be present in certain cases of physical diseases (e.g. chronic pain) and in certain cases of physical and psychiatric comorbidity (e.g. severe borderline personality disorder in a person with heart failure). In fact, such patients can have access to MAID now, depending upon their clinical condition. Therefore, this uncertainty is inevitable and is not limited to requesters with MD-SUMC.

In strictly medical terms, "incurable" refers to the reversal, halting, or elimination of an underlying pathophysiological process of a disease. The underlying pathophysiological processes involved in most mental disorders are unknown. Instead, mental disorders are defined by their symptom profiles and treating disorders usually involves symptom reduction. But symptom reduction may not necessarily be a patient-centred outcome of treatment; therefore, "incurable" has to be understood with the patient's goals of treatment in mind.

What factors can be employed to assess the incurability of a mental disorder or the advanced and irreversible decline of a person's medical situation?

3.1.1 Chronicity

According to the AMPQ survey, 71% of Québec psychiatrists believe that the minimal duration of lived experience of illness should exceed 5 years before being able to accept a request for MAID MD-SUMC and 42% believe that it should be at least 10 years (AMPQ 2020). Incurability of a mental disorder can only be determined over the long term, following numerous treatment trials and observation of their outcomes. The specifics of prognosis cannot be determined by diagnosis, lab tests, personality traits, or social factors.

In assessing incurability and irreversibility of decline, the physician should carefully examine the therapeutic options that have been offered, tried, and that remain, if any. A medication trial can take several months and psychotherapy and rehabilitation programs can take up to 2 to 3 years. Treatment algorithms exist for "refractory" conditions illustrating that even they are not necessarily considered incurable. As an example, after at least two antipsychotic trials at optimal doses for several months, including a long-acting injectable medication, a psychotic disorder can be considered refractory (Howes et al. 2017). However, there are other treatment possibilities

[14] Operating in the background of all clinical decisions is an ethical judgment of the sort: is it ethically right to intervene in this way with this patient at this time? These considerations are generally covered by laws guaranteeing the right to informed consent, the regulatory framework that determines allowable medical interventions, and the fiduciary duty of doctors to patients. Similarly, each and every time a practitioner is asked to provide medical assistance in dying, she makes an individual ethical judgment of the sort: is it right for me to assist this person to end her life? Again, we are referring here to professional ethics, not the individual's values.

In order to conclude that a condition is incurable, a psychiatrist must determine which biological, psychological and social interventions have already been tried.

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The interventions tried ought to be compared to recognized practice guides for the mental disorder(s) affecting the person.

to consider. A trial of clozapine is indicated and is often effective. Combination strategies or other treatment modalities such as electroconvulsive therapy can be considered. Alongside these approaches, cognitive-behavioural therapy for delusions and psychosocial rehabilitation should be offered. Québec psychiatrists believe that one cannot consider a condition incurable before one has had a long period of psychiatric follow-up (at least five years according to 55% of respondents) (AMPQ 2020). It is also important to recall that partial or complete improvement is possible for certain disorders even without specific treatment.

The chronicity of a disorder is an important factor to consider. However, any specific time requirement for the minimal duration of experience of illness or of psychiatric follow-up would be arbitrary.

3.1.2 Treatment History

In order to conclude that a condition is incurable, a psychiatrist must determine which biological, psychological and social interventions have already been tried. She must take into consideration:

- the specific types of interventions
- whether the interventions were subject to fair trials (e.g., optimal doses of medications, sufficient number of psychotherapy sessions)
- why the interventions were ceased (e.g., side effects, lack of effectiveness);
- the person's experience of treatment and relationships with the clinicians involved
- any other factors that may have modified the effectiveness of an intervention (e.g., pressure not to pursue the intervention by someone in the person's social circle, comorbid medical condition modifying pharmacokinetics).[15]

The interventions tried ought to be compared to recognized practice guides for the mental disorder(s) affecting the person in order to identify whether there exist reasonable options to suggest.

The NVvP proposes (and is supported by the VVP) the following approach to circumscribe what constitutes a reasonable treatment option:

"According to current medical opinion, there will be: a) a prospect of improvement if adequate treatment is received, b) in the foreseeable future, c) and with a reasonable balance between the results that can be expected and the toll the treatment will take on the patient." (VVP 2017, 16)

According to these guidelines, a prospect of improvement means that a treatment will bring about relief or partial relief of suffering, the reversal of decline or both. Improvement should be understood in light of the impairments resulting from the mental disorder and the gains the person wishes to achieve in order to improve their quality of life. The recovery-oriented approach to mental disorders offers a useful perspective on the goals of care. It holds that people can live "satisfying, hopeful, and contributing lives" (College of Family Physicians of Canada 2018, 3) despite the presence of chronic symptoms.

[15] The assessor may require access to a requester's medical records in order to obtain this information. If the requester refuses access, the assessor will be unlikely to complete the assessment.

The balance between expected results and the burden of a treatment must take into consideration the probability of achieving the expected improvement and the probability of experiencing serious side effects or other harms.

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Adequate treatment should include at least first- and second-line treatments, recognized psychotherapeutic modalities, and recognized social interventions.

Adequate treatment should include at least first- and second-line treatments, recognized psychotherapeutic modalities, and recognized social interventions. The foreseeable future cannot be defined as lying within a specific timeframe, but needs to be individualized in light of the duration and outcomes of treatments already tried, the duration of any proposed treatment, and the age and health of the person. The balance between expected results and the burden of a treatment must take into consideration the probability of achieving the expected improvement and the probability of experiencing serious side effects or other harms.

The availability of therapeutic interventions can vary considerably depending on where a person lives, the local service organization, and one's individual financial means. Unfortunately, access to mental health services is often suboptimal in several regions in Québec, from first-line care to specialized programs. Every effort must be undertaken to provide appropriate care to patients with intolerable suffering, whether that includes the first line of intervention or new and promising therapies.

3.1.3 Treatment Refusal

What if a person requesting MAID MD-SUMC refuses an intervention offering a reasonable chance of improvement as defined above? Is this person automatically considered incurable or in a situation of irreversible decline?

During the debate on Canada's original MAID law, then-Minister of Health Jane Philpott, herself a family physician with decades of clinical experience, appearing before the Senate of Canada, pointed out that incurability is a clinical judgment:

> "On the matter of curability, there are a lot of reasons why something is incurable. Sometimes it's because no cure is known. Sometimes it's because, for the cure that is available, the patient has a contraindication to whatever that treatment might be. Sometimes there's no access to that treatment in a particular country. Sometimes it's a matter that the doctor and the patient make the decision that the particular treatment is inappropriate given the circumstances. Sometimes people are not able to be cured because of the fact that there's a requirement in the relationship between a provider and a patient of informed consent and that a patient needs to consent to accept a treatment. All of those situations need to be necessary for someone to be able to avail themselves of a cure. This is a way of being able to define the specific circumstance in which the doctor is looking at this patient and saying, *"I cannot cure this patient's problem, and therefore they meet the criteria."* (Debates of the Senate, June 1, 2016, 766)[16]

A capable person can refuse a treatment that the physician believes offers a reasonable possibility of relieving his suffering. Whether he will be considered incurable and ultimately eligible to access MAID will depend on the kinds of considerations stated above and the entirety of his clinical situation discussed together in therapeutic dialogue.

A capable person can refuse a treatment that the physician believes offers a reasonable possibility of relieving his suffering.

[16] This passage did not concern specifically people requesting MAID MD-SUMC.

Case Vignette

A 53-year-old man has had a major depressive disorder since the age of 29. He has been divorced since the age of 35 and has no children. He has cordial but limited contact with his ex-wife. He is followed closely by this treating team, a specialized service of the hospital in his area. He has had several depressive episodes in the past involving multiple individual and combination medication trials, psychotherapy, and involvement in several community support programs. He had ECT during his first episode and has been maintained on medication since that time. He has never experienced a complete remission of symptoms and is quite functionally impaired: unable to work, no social contacts. He has had suicidal thoughts over long periods but has never made an attempt as he is afraid he could end up worse off than he is now. He has been offered ECT but declined. He asks his treating psychiatrist for MAID.

This case illustrates the challenges in assessing the incurability of a condition and the irreversibility of decline. It also raises the question of whether the refusal of ECT affects the assessment of incurability or irreversibility of decline.

Mental disorders can cause as much suffering as other medical conditions.

3.2 SUFFERING

The assessment of the criterion of "intolerable suffering" is a puzzle. In those countries with a similar eligibility criterion, it is this one that is most challenging during the clinical assessment (van Tol et al. 2010, 167). If this criterion is understood entirely in subjective terms, it seems odd that it is an eligibility criterion at all as there is nothing to assess once the person has affirmed her state of intolerable suffering.

Most commentators agree that mental disorders can cause as much suffering as other medical conditions (Council of Canadian Academies 2018, 75). Symptoms themselves can be a source of suffering, for example, denigrating auditory hallucinations, irresistible hand-washing compulsions, or recurring suicidal thoughts. The functional decline that results from symptoms can also be a source of suffering, such as the inability to leave one's home due to severe agoraphobia or post-traumatic stress disorder, the inability to work due to weakness arising from several anorexia nervosa. The psychiatrist must assess the severity of symptoms, the degree of functional incapacity over time, coping mechanisms and how these have evolved over time.

Serious functional incapacity can lead to social vulnerability (unstable housing, socioeconomic disadvantage, social exclusion and isolation). Because the social determinants of health can play an important role in contributing to suffering for a person living with a mental disorder, their suffering may be due to or at least shaped by these social injustices, rather than by the disorder itself (Council of Canadian Academies 2018, 49). According to this line of thinking, providing MAID in such cases would be an individual and medical response to a societal-level failure. Strategies to improve those social circumstances contributing to suffering ought to be attempted before conclusions about a person's eligibility for MAID are drawn.

The psychiatrist must assess the severity of symptoms, the degree of functional incapacity over time, coping mechanisms and how these have evolved over time.

Strategies to improve those social circumstances contributing to suffering ought to be attempted before conclusions about a person's eligibility for MAID are drawn.

At the same time, this concern is not unique to persons requesting MAID MD-SUMC. There are numerous groups of patients who are socially vulnerable. Indeed, cases of elderly patients requesting MAID because they can no longer live independently but do not want to move into a public nursing home illustrates the very real role social factors can play in an individual's decision-making (Noël 2019). The fact that a certain group is at greater risk of experiencing certain vulnerabilities does not mean that each individual member of the group is equally vulnerable. Indeed, some individuals may not be or may not perceive themselves to be socially vulnerable and do not wish to be treated as such.

Mental disorders can affect one's cognitions, feelings, perceptions, and judgment. This in turn can have an impact on one's perception of or experience of suffering.

Suffering is multifactorial. Beyond the direct impacts of mental disorder, functional decline and social vulnerability on one's perception of suffering, the psychiatrist must explore other factors that affect a patient's experience. These include the patient's:

- family and social situation
- overall state of health
- values
- sense of meaningfulness in life
- personality traits
- circumstances in which the person has felt better or worse
- bereavement and experiences of loss

When a psychiatrist attempts to appreciate a person's appraisal of her suffering, he will have to take into consideration the influence of the person's mental state on that appraisal.

Having done so, the psychiatrist will be in a better position to understand the patient's suffering and consider whether avenues apart from MAID can contribute to its relief.

The psychiatrist must estimate how realistic a person's expectations, hopes or hopelessness are about the future. If a person's suffering is based on irrational, dysfunctional, or pathological beliefs or emotions, it may not be appropriate to proceed with MAID.

SECTION 3. MAID AND THE SPECIFICITY OF MENTAL DISORDERS

In psychiatry, we are sometimes confronted with situations in which a person's appraisal of her own situation can be faulty or misguided. Indeed, mental disorders can affect one's cognitions, feelings, perceptions, and judgment. This in turn can have an impact on one's perception of or experience of suffering. For example, affective disorders can make experiencing pleasure difficult, create cognitive distortions[17] which augment the impact of negative events while preventing consideration of positive ones. Further, depression can influence one's judgment such that one's evaluation of a situation is more pessimistic than it would be if the person were not depressed. When a psychiatrist attempts to appreciate a person's appraisal of her suffering, he will have to take into consideration the influence of the person's mental state on that appraisal.

It is important to take the time to develop an understanding of a person's suffering through intersubjective exploration, a necessary feature of an assessment for MAID MD-SUMC. (Gupta et al. 2017, 9; Swiss Academy of Medical Sciences, 2018, 24). The psychiatrist must estimate how realistic a person's expectations, hopes or hopelessness are about the future. If a person's suffering is based on irrational, dysfunctional, or pathological beliefs or emotions, it may not be appropriate to proceed with MAID.

Case Vignette

A 48-year-old single man has always found his nose to be out of proportion to his face. He thinks people stare at him as a result and find him ugly. He has had several plastic surgery procedures to try to correct his appearance but he is still distressed by it. He seeks out 'miracle' treatments online and various creams which he applies to his face and nose against the advice of doctors. On other occasions he shows up in plastic surgery clinics without an appointment, begging to be seen. Because of his history, the plastic surgeons in his city will not see him anymore. The patient has been referred to psychiatrists on several occasions but he refuses to go. He goes to his local CLSC asking if he can have MAID. He sees no way out and cannot live with his appearance as it is.

This case illustrates the difficulty in accessing and exploring suffering in a patient who will not be seen by a psychiatrist and who appears to be closed to non-surgical approaches to his problems. Even if he agrees to meet a psychiatrist because he cannot otherwise access MAID, the interaction may not be fruitful. His suffering seems to be motivated by a set of unfounded beliefs about his appearance yet is serious enough to make him consider MAID as his only option.

3.3 DECISIONAL CAPACITY

Both the Canadian and Québec laws require persons seeking MAID to be capable at the time of the request and at the time of administration.[18] In Québec, the requirements for decisional capacity are laid out in regulatory standards[19], rather than in a specific law. In its MAID practice guide, the CMQ suggests that capacity evaluation be based on an assessment of 'four cognitive abilities' (CMQ 2019, 23):

1. Understanding information according to the five Nova Scotia criteria
   - Does the person understand the nature of the condition for which she is requesting MAID?
   - Does the person understand the nature and purpose of MAID?
   - Does the person understand the benefits and the risks of MAID (and alternative treatments, including not having MAID)?
   - Does the person understand the risks and consequences of not pursuing MAID?
   - Is the person's capacity to understand affected by the condition?
2. Appreciation of the information
   - Can the person appreciate the information provided about the options, apply it to himself, and demonstrate insight?
3. Reasoning about information
   - Is the person capable of comparing the risks and benefits of each option, of evaluating the pros and cons of each option, and of justifying her choice?
4. Communicating a choice
   - Can the person communicate a consistent and reasoned choice?

[17] At the same time, cognitive distortions in and of themselves are not unique to mental disorders and can also occur in persons who do not have mental disorders. See Dembo et al. 2020.

[18] C-7 creates a pathway for those in the "natural death reasonably foreseeable" group, and who were capable at the time of assessment, to receive MAID even if they lose capacity in between approval and the time of administration.

[19] For example, the CMQ has published a guidance document on consent to care.

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We also recommend that the assessor go beyond the cognitive criteria mentioned above—or at least a cognitive interpretation of these criteria—and consider whether emotional reactions, interpersonal dynamics, and values arising from the disorder are having a negative impact on the individual's ability to consider options and make judgments.

Some psychiatric disorders may compromise various aspects of decision-making for certain people without necessarily affecting cognitive function. The criteria above reflect certain cognitive abilities but do not include other aspects of decision-making such as mood, values, and coherence with identity (Charland, 1998; Grush and Damm, 2012; Kontos et al. 2015). We believe the concept of capacity would be strengthened by ensuring that these other spheres are given consideration, not only for decision-making about MAID, but for any high-stake healthcare decisions.

For example[20], persons who have experienced severe childhood trauma may be able to reason about MAID and its alternatives, but the pervasive self-denigration that is common among survivors may distort their appraisal of their prospects (Halpern 2012). Cases of persons severely affected by anorexia nervosa, who privilege being thin over their survival, illustrate how values stemming from psychopathology can affect decision-making. A person affected by chronic major depressive disorder might underestimate his potential for recovery or perceive himself as a useless burden to his significant others. Complex interpersonal dynamics associated with borderline personality disorder in which a person expresses verbally a seemingly informed refusal of treatment but expresses a desire for treatment and care in his actions offers another example of additional considerations that seem to go beyond the cognitive criteria (see Ayre et al. 2017 for a description of the challenges involved in these types of cases).

We recommend that evaluating decisional capacity in the context of MAID MD-SUMC be longitudinal over the course of the various clinical encounters required and not based on a single meeting. We also recommend that the assessor go beyond the cognitive criteria mentioned above—or at least a cognitive interpretation of these criteria—and consider whether emotional reactions, interpersonal dynamics, and values arising from the disorder are having a negative impact on the individual's ability to consider options and make judgments.

A difficult problem arises when faulty beliefs about the self or distorted interpretations and maladaptive emotional reactions are so chronic and deeply held that it is no longer possible to talk about what the person really wanted or was like before they became ill. Clinically, we face the same challenge when patients with these types of problems have to make potentially life-ending decisions involving the refusal of care. Furthermore, such problems may arise in the current practice of MAID when patients with these problems

[20] These examples do not mean to imply that person in these circumstances are necessarily incapable of consenting to MAID.

are at the end of life and request MAID. There is no easy response to this situation. In such cases, the best the physician can do is to affirm the value of the person's life and try to have the most complete understanding of the person, including their vision of a good life, so as to act in a manner that best respects that vision.

Capacity assessors may disagree among each other (Kim et al. 2006; Doernberg et al. 2016). When it comes to a high-stakes decision such as to pursue MAID, is disagreement acceptable? While a person's decision-making capacity is dependent on certain measurable cognitive abilities, capacity assessments themselves are clinical judgments based on the normative standard established by society as to what a person has to be able to do, say, feel and think in order to be allowed to decide for herself. On matters of judgment, competent assessors may disagree. Disagreement in and of itself does not threaten the legitimacy of the capacity assessment process. On the other hand, intractable disagreement may signify that there is too much uncertainty to proceed.

Case Vignette

A 45-year-old woman has an alcohol use disorder, as well as an unspecified personality disorder. She is constantly angry both when she is drinking and when she is in withdrawal. She has no contact with her family and does not want any. In the last two years, streptococcal infections caused by extremely poor hygiene have badly damaged parts of her face (her nose, cheek and one eye). Surgery has been attempted but because she refuses all care, her wounds are regularly reinfected. She requests MAID.

This case illustrates the challenges of assessing decisional capacity. Simply being able to engage the patient in the assessment process may prove difficult. Whether this can be done when she is not intoxicated and not undergoing withdrawal is uncertain. Thus far, she has been making her own treatment decisions but this may also need to be reconsidered. The practical question of how to manage her self-negligence further complicates her care and a potential MAID assessment.

3.4 SUICIDAL THINKING

The expert testimony in the Truchon-Gladu case exposed the divergence of views concerning the relationship between suicide and MAID MD-SUMC. Among these were the concerns that a request for MAID MD-SUMC reflects suicidal thinking which could be a symptom of a person's mental disorder, that MAID MD-SUMC is a form of suicide, and that allowing MAID MD-SUMC may act to the detriment of society's suicide prevention efforts (*Truchon c. Canada [procureur général]*, [2019] QCCS 3792, para. 325-326; para 322).[21] Is it somehow contradictory to be aiming to prevent suicide among people with mental disorders, on the one hand, and making MAID accessible to them on the other?

In the three countries where MAID MD-SUMC is permitted (Netherlands, Belgium and Switzerland), there are active suicide prevention strategies, as well as similar medicolegal mechanisms to those that exist in Québec, to protect a person from harming himself due to a mental disorder. This suggests that these practices need not be considered contradictory and that they can and do co-exist in law and policy. However, in a clinical setting, it may be unclear when a clinician should draw upon suicide prevention strategies for a person who is also requesting or considering requesting MAID MD-SUMC.

In such a case, understanding suicidal ideation is essential. What are the person's beliefs about death? How and why did they come to choose MAID as an option? Why does the person want to die? What would dying change?

Indeed, suicidal thoughts, threats, and attempts can emerge as a response to suffering related to the following:

- Difficult feelings (e.g., shame, guilt, humiliation, loneliness, fear, bereavement) (Shneidman 1993)
- An interpersonal situation such as feeling alone without human connection or seeing oneself as a burden to those around her (Joiner 2005)
- Hopelessness (Beck 1974)
- An expression of anger towards the self or others as a solution to stop suffering (Meninger 1938)

[21] In the decision itself, after weighing the expert testimony, Judge Baudouin rejected the idea that all requests for MAID outside of the end of life could be considered suicide attempts.

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In assessing suicidal thoughts, the psychiatrist attempts to discern a person's underlying motivations and offer alternative solutions to suicide. For example, a man with a narcissistic personality disorder who never recovered following the infidelity of and divorce by his spouse may request MAID out of a desire to hurt his ex-wife. An apposite intervention would be to help him to become aware of his anger and express it in an appropriate manner.

Other aspects to consider in a MAID assessment:

- The requester's affect
- Transference and countertransference in the doctor-patient relationship. Is the request for MAID a way for the patient to ask the psychiatrist if she has lost hope, if she will abandon them or remain with them, or if she understands their suffering?
- Past suicidal thinking, whether occasional or chronic, ego-syntonic or ego-dystonic. Ego-dystonic suicidal thinking is easily recognizable as a symptom of a disorder and can be a major source of suffering for a person, particularly if it is intrusive Ego-syntonic suicidal thinking can reflect one's distress or can be a means of communication. This type of suicidal thinking can be difficult to distinguish from a well-considered request for MAID, particularly when it is chronic
- Past history of suicidal thinking, gestures, or attempts and their similarities to or differences from the MAID request

In medicine, including in psychiatry, respect for a person's autonomy sometimes requires accepting a person's decisions that could lead to her death. In other situations, suicide prevention strategies are deployed, include coercive measures such as hospitalization against one's will. Thinking through what motivates our clinical actions in these more familiar circumstances may help to advance our understanding of the relationship between MAID and suicide if MAID MD-SUMC is to be practised.

All persons with decision-making capacity—including those with mental disorders—can refuse treatment and care up to and including lifesaving and sustaining treatment. In the hospital setting, psychiatrists are sometimes consulted in such cases to assess capacity but also to explore the possibility that symptoms of a mental disorder are influencing the decision, even if they are not compromising legal capacity. Examples might include a magical belief about one's ability to survive or a self-destructive decision in the context of harmful interpersonal dynamics. In fact, physicians tend to prevent people from acting or deciding for themselves when we think a person is unable to exercise good judgment about her own interests. In such a situation, a person may be asked to take more time for reflection, speak with a trusted person, gather more information, or engage in dialogue about the situation with the clinical team. If these options do not result in a decision that the treating team perceives as rational and considered, they may go as far as to seek court-ordered treatment in order to treat a person against her will. In other situations, the person's decision is respected even if physicians find it disquieting. Acceptance of such a decision is facilitated when it seems that the person is making a judgment in her own interests. We may conclude that this is the case when, for example, a person understands the relevant issues, is emotionally at ease with her decision, her choice is consistent with her beliefs and values, and her choice is persistent in time. In such cases, we may wonder whether the treatment refusal is a form of suicide, but we do not conclude that it is to be prevented in all cases.

The situation of a person with chronic suicidal thinking illustrates a different point. Our approach to suicide prevention is not based on decision-making capacity, but on intended action. That is, we try to interfere in people's actions, including through the use of legal coercion, when we think it is likely they will act in the short term. However, if a person expresses chronic suicidal ideas but no specific intent to act, we continue to provide clinical care, we offer understanding and acceptance that this difficult subject can be addressed openly, and we recommend suicide prevention resources, but we do not force interventions upon them, even if eventually they refuse or drop out of care. Although suicidal thinking may be a symptom of their mental disorder, such persons are allowed to go about their lives in the community, making decisions and acting in a variety of spheres of life even though they are at chronic risk of committing suicide. Clinical action is motivated by practical and legal reasons. (We cannot involuntarily hospitalize every person who expresses a suicidal idea, particularly if we do not have reason to believe they intend to act in the short term.) But these practical and legal reasons are themselves underscored by the ethical norm that people's decisions and actions should be respected except in extreme circumstances.

SECTION 3. MAID AND THE SPECIFICITY OF MENTAL DISORDERS

As some have pointed out, as a group, those who request MAID MD-SUMC and those who are considered suicidal share certain characteristics, suggesting at the very least that there is overlap between these groups. Others assert that these are distinct groups (Kim et al. 2018). Clinically, a person who requests MAID MD-SUMC, who is prepared to engage in a process of reflection with her doctor and who expresses no wish to act independently to end her life shares similarities with a person with a mental disorder who expresses suicidal ideation chronically, does not act and seeks mental healthcare. In both cases, the person's thoughts could reflect reasoned judgments or they could be symptoms of their disorder. However, in situations when a person makes choices that may or will lead to death, our clinical actions are not based on the empirical characteristics of groups to which they belong (e.g., if someone expresses a wish to refuse a life-sustaining treatment, we do not ask if the person belongs to a sociodemographic group with an elevated risk of suicide and, if she does, we prevent her from making her decision). Our clinical decisions are made along ethical lines, including decision-making capacity and the ability to act in one's interests. Similarly, the clinical decision to provide MAID MD-SUMC will rely on the ethical considerations that motivate our actions in all cases in which someone is acting in ways that might bring about her death (den Hartogh 2019).

A person might request MAID MD-SUMC and during the assessment process, or even once determined to be eligible, express suicidal ideas, formulate a plan, or make a suicide attempt. Although this may seem to be a surprising possibility, this situation can and does arise even at present in MAID practice. In such cases, the usual clinical steps in crises should be adopted, from urgent contact with the person, provision of resources and support, intervening in the stressor (if there is one) that is leading to suicidality, and even hospitalizing the person against her will if she is an imminent harm to herself. Although the person is pursuing a MAID request, this does not exclude such efforts, including the opportunity to reinvest in life.

Case Vignette

A 24-year-old woman has been diagnosed with a borderline personality disorder, as well as anorexia nervosa as an adolescent. She has attempted suicide many times (jumping from a window and in front of a subway car, overdoses). These attempts have left her with serious sequelae (partial paralysis, neurogenic bladder, multiple leg and hip fractures). Over the last three years, she has been engaging in self-harming behaviours on a regular basis. She tends to refuse treatment during such episodes. The severity of her eating disorder fluctuates. At times, her body mass index has been as low as 12. Currently it is around 16. She requests medical assistance in dying.

In this case, the person is engaging in both acute and chronic self-harming behaviours. She has also requested MAID. Her situation illustrates the difficulty of disentangling symptoms and self-harm from what could be a reasoned assessment of her circumstances.

Section 4. Recommended MAID MD-SUMC assessment procedure

A proposed assessment procedure must take into consideration the demographic and geographic characteristics of Québec. The population of Québec is estimated to be 8,484,965, divided over 17 administrative regions covering a territory of 1,300,796 km^2 (Institut de la statistique du Québec 2020). While psychiatry is a primary-care specialty, access to mental health services varies enormously from region to region. For example, Montréal, with a population of approximately 2,029,400 (around 25% of the total population of Québec), is served by a third of the province's physicians and has several major hospitals and specialized clinical institutes. At the same time, 35% of those who live in the region do not have a family physician, compared with 20% in the other regions (Institut de la statistique du Québec 2020). The region of Northern Québec has 45,600 inhabitants but occupies almost half of the land mass of the province. This region has several physically isolated communities without access to physicians, let alone mental health professionals. The majority of the Inuit people in Québec live in Nunavik, which lies within this region. This population has one of the highest suicide rates in the world and faces numerous issues of social inequity, including inadequate access to culturally safe mental healthcare.

4.1 PREREQUISITES

We believe that the practice of MAID MD-SUMC requires specialty and subspecialty knowledge of and experience in the treatment of mental disorders. Psychiatrists must be involved as both the first and second assessors. We anticipate that most people who request MAID MD-SUMC will already be followed by psychiatrists and, thus, the treating psychiatrist can act as the first physician. If a person's treating physician is a family doctor, we believe that two psychiatrists are required for the MAID assessment process due to the specialized expertise required.

However, we are concerned about the variable access to psychiatric care from one region to another, as well as the difficulties experienced by patients and families trying to navigate the mental healthcare system. We are also aware of the controversial nature of this practice and the criticisms of the quality of the evaluations in certain cases that have been publicized in the media and analyzed in academic work. Thus, we believe that the practice of MAID MD-SUMC will be best undertaken if there is province-wide coordination to ensure appropriate access to psychiatrists and a structure for prospective oversight. In order to achieve these aims, we call for the creation of a new clinical-administrative entity, the Bureau régional d'AMM lors d'un problème de santé mentale (BRAMM-SM), whose roles are both administrative and substantive. There will be a BRAMM-SM in each of the four university-affiliated regions (RUIS).

Its administrative functions will be to:

1. Ensure that each request is addressed within the required timeframe[22]
2. Ensure procedural consistency between regions
3. Assist in identifying assessors and providers for each request
4. Ensure that the process is transparent
5. Ensure that a final decision is made and communicated to requesters
6. Conserve the documentation associated with all requests

Its substantive roles will be to:

1. Provide oversight of the assessment process by reviewing the documentation of the assessments in a prospective manner in real time and not *a posteriori*. The oversight process will ensure that assessors have considered and explained their reasoning regarding the eligibility criteria. The committee's role is limited to requesting further information when it judges that a subject requires greater explanation. The BRAMM-SM will not conduct its own eligibility assessment of a requester.
2. Provide formative feedback to assessors with the goals of improving the quality of care and decision-making

[22] We recommend that each step in the assessment process outlined below be completed within a specified timeframe in order to reassure people that their requests will not face the barrier of lengthy delays.

In its substantive role, the BRAMM-SM will give particular attention to certain crucial aspects, including:

a) The independence of the second assessors vis-à-vis the requester

b) That the assessment process is carefully followed

c) That the eligibility criteria have been carefully explored and documented

d) That assessors considered the dynamics surrounding a person's request for MAID, as well as elements of his social context[23]

e) That suicidality (as a symptom of a mental disorder) has been explored

The BRAMM-SM can request additional information from the involved parties throughout the process if documentation is lacking. Physicians can also consult the BRAMM-SM for advice and guidance.

The BRAMM-SM will require staff to fulfill the administrative functions described above. To that end, it could be integrated into existing institutions such as the Tribunal Administratif du Québec in order to take advantage of extant administrative structures. The BRAMM-SM will also create an oversight committee to fulfill its substantive role. It will keep a roster of members[24] who are willing to serve on the oversight committee, which will be convened for each case.

In what follows, we present a four-step pathway for a request for MAID MD-SUMC. In this description we have modified the existing MAID assessment process in Québec by integrating certain practices already in existence in the Netherlands and Belgium with respect to such requests. We believe this to be necessary as the existing process in Québec was intended for persons at the end of life, where the issues and time constraints are different. We also indicate the role and timing of the BRAMM-SM's functioning.

4.2 THE PATHWAY OF A REQUEST FOR MAID MD-SUMC

The fundamental stance which should structure the entire process and the interventions of each person is the "twin-track" approach (VVP 2017, 9). This approach recognizes the compatibility of continuing therapeutic activity with a person to improve the quality of her life while also respecting her wish to undertake the MAID assessment process. Practically speaking, it means that a requester's treating team will remain involved in the care of the person and will continue to explore treatment and rehabilitative options. It also means that all clinicians involved, whether those in the treating team or those involved in the MAID assessment process, can discuss both recovery and MAID with the requester. In so doing they recognize that, while respect for individual autonomy and the value of life may be in tension with each other in a MAID request, the assessment process need not be polarizing and thus may itself have therapeutic potential.

First step: the initial request

- The formal request is presented by the person to their attending physician (family doctor, psychiatrist or other specialist). The request must meet the usual legal requirements.
- The attending physician must decide if she will act as an assessor or not. Apart from objections of conscience, clinical considerations specific to psychiatric practice might lead a psychiatrist to abstain from assessing MAID eligibility for her patient. For example, there can be issues in the transference and/or countertransference or the physician may feel too emotionally involved with her patient in order to be able to do a good assessment. In certain cases, the fact of not being involved in the assessment will better enable the treating physician to pursue her therapeutic role. At the same time, we recognize that not being an assessor creates a dilemma: the attending physician is likely to know the patient better than a third-party assessor. In this case, we suggest that she contribute her point of view at a later phase (see Step 4).

[23] We identified these aspects by reviewing case reports of euthanasia for mental disorders published by the Dutch oversight committee (RTE) that were considered not to have respected the due care criteria in that country. The RTE provides retrospective oversight. Our proposal is for the BRAMM-SM to provide prospective oversight paying careful attention to these areas of weakness identified by the RTE in the clinical documentation of cases of euthanasia for persons with a mental disorder.

[24] The qualifications and composition of the oversight committee will have to be determined in consultation with the CMQ, the CFSV, and other organizations they believe should be included.

- The physician sends the request to her designated BRAMM-SM.
- If the person does not have an attending physician, or if the latter cannot participate or objects for conscience reasons, they can contact the BRAMM-SM, which will coordinate the process.

Second step: BRAMM-SM opens a file for the requester (4 weeks)

- If the request complies with the usual legal requirements, the BRAMM-SM will organize an assessment with an independent psychiatrist (or two, if the treating psychiatrist abstains from participating or is a family physician).
- If the request is rejected, the following steps should be undertaken:
  - The Committee must explain in writing the reasons why the request was refused.
  - The letter is sent to the attending physician and the requester.
  - The physician will explain the reasons for the refusal to the requester and remain actively involved in the person's care.

Third step: Eligibility assessments (16 weeks)

- The psychiatrist-assessors are independent from each other. They must conduct a rigorous examination of the overall clinical situation (see Appendix A) and conduct a dynamic assessment process so as to arrive at the most appropriate decision given the circumstances.
- First assessment: the first psychiatrist involved must be competent with respect to the specific disorder that is motivating the request. She must assess all criteria with a particular emphasis on the incurability of the disorder, the irreversibility of the decline and the potential alternatives to relieve the suffering of the person.
- Second assessment: the second psychiatrist will assess all of the eligibility criteria.
- The assessors should meet with the requester's significant others unless this is contraindicated or refused.
- The assessors should seek out the perspective of other clinicians involved in the requester's care (e.g., psychologist, social worker, etc.).
- With the requester's consent, the assessors should obtain reports from earlier MAID requests.
- Once the assessors have obtained all the necessary information to arrive at a decision, each will write a written report explaining their judgment as regards eligibility for MAID.

This process may seem unwieldy but the requirement for two psychiatric assessments exists for other decision-making processes in medicine, such as for involuntary hospitalization. An assessment by three physicians, of whom two are psychiatrists, is also recommended by the NVvP and the VVP.

Fourth step: Prospective monitoring and decision-making (8 weeks)

- The members of BRAMM-SM's oversight committee must review the assessors' reports to ensure that they have clearly explained on what basis they concluded that the eligibility requirements were met or not met. In doing their review, they may request additional information.
- Once the oversight committee considers that both assessments are complete, the two physicians meet. We recommend that other clinicians involved in the patient's care and who are in regular contact with him attend the meeting.
- Each assessor explains their point of view. The attending physician participates in the discussion even if she did not act as an assessor; however, the responsibility for the final decision concerning MAID eligibility is made by the two assessors.
- The assessors try to arrive at a shared conclusion even if they do not agree on every point.
- Once they have reached a conclusion (eligible, ineligible or in disagreement), the assessors prepare a report indicating the decision, the reasons behind it, and their recommendations for therapeutic alternatives. This report is submitted to the BRAMM-SM.

If the requester is considered to be eligible:

- The attending physician must clearly explain to the requester the reasons for the acceptance.
- With the consent of the requester, the attending physician meets with the family to explain the decision.
- The attending physician maintains an open and continuous dialogue with the person about the decision. He makes sure that the person knows that he can withdraw from MAID anytime and by all means.
- The waiting period required by law is respected. The attending physician remains present and actively involved in the person's care, specifically ensuring the person's safety in case of suicidal intent and following up on the therapeutic recommendations made by the assessors.

If the requester is considered to be ineligible:

- The attending physician must clearly explain to the requester the reasons for the refusal.
- With the consent of the requester, the attending physician meets with the significant others to explain the decision.
- The attending physician maintains an open and continuous dialogue with the person about the decision.
- The attending physician remains present and actively involved in the person's care, specifically ensuring the person's safety in case of suicidal intent and following up on the therapeutic recommendations made by the assessors.

If a request is refused or a person chooses not to proceed with MAID, he must wait for a period of time to be specified later before a new request can be initiated.

In the case of disagreement between the two assessors, the opinion of a third psychiatrist chosen by the BRAMM-SM is required. This third assessment will finalize the process by rendering a majority decision.[25] This assessor must explore all the criteria. She will have access to the summary of the assessors' meeting and their reports. The third psychiatrist's report is subject to the same scrutiny by the oversight committee as that of the first two assessors. Once the decision has been made, the steps above will be followed.

In light of the complexity, uncertainty, and divergent views within the clinical community, if MAID MD-SUMC is to be practised, we believe it must be done with the greatest of prudence. This proposed system is laborious and prolonged for the right reasons: so that everyone involved, including the requester himself, can develop a full understanding of why the request is being made; so that every opportunity is offered to improve the person's situation; and so that there is sufficient time, structure, and guidance to ensure the process is properly carried out. Despite the intensive assessment process, the BRAMM-SM will offer a dependable bureaucracy, providing requesters timely and consistent access to the process across the province.

4.3 REQUESTS FOR MAID MD-SUMC IN SPECIAL CLINICAL SITUATIONS

4.3.1 Persons with neurodevelopmental disorders

While neurodevelopmental disorders such as intellectual disability and autism are included in the DSM, there is debate within these communities as to whether these are medical conditions, handicaps or simply differences. This question is particularly relevant to those persons who are mildly affected and high-functioning. This issue has important implications for the debate about MAID access. For example, if such conditions are not "illnesses" (Québec) or "illness, disease or disability" (Canada) in the sense of the law, then they cannot be considered a sole underlying medical condition in and of themselves. If they are illnesses, diseases or disabilities in the sense of the law, then they can.

Turning specifically to the population of persons with intellectual disability, the possibility of access to MAID must be understood in light of the historical practice of eugenics and current-day practices of fetal selection based on trisomy 21. It is important to note that this group of persons is highly heterogeneous, yet, as individuals, they face similar challenges in obtaining appropriate services to improve their ability to function, social supports, and housing. They are also more vulnerable to all types of abuse and some are particularly susceptible to external pressure. However, it is also important to balance these considerations with ensuring full access to their rights as citizens, including their entitlement

[25] By definitively ending the process, we wish to avoid a situation where expert advice is sought repeatedly until the desired decision is reached.

to self-determination given past practices in which capacity and decision-making authority were routinely denied. Their requests, including for MAID, should be assessed on a case-by-case basis, with particular attention to decisional capacity and the full range of social vulnerabilities.

4.3.2 Persons under legal constraints

Persons with mental disorders may find themselves subject to several different types of legal constraints. In the civil system, they may be hospitalized against their will, where they may also be subject to legally required treatment authorized by a substitute decision maker. They may be subject to mandatory community treatment orders authorized by legal authorities such as courts or administrative tribunals. In the criminal system, they may be in prison awaiting trial or serving a sentence or they may be in psychiatric facilities having been found not criminally responsible. Despite these constraints, such persons should not be subject to differential treatment concerning MAID because of their legal status.

Those who are under court-ordered care in the civil system may request MAID due to the hardship of living with coercive treatment, particularly when this has been longstanding. Particular attention must be given to trying to negotiate a non-coercive therapeutic regime before making decisions about MAID eligibility.

There are particular problems associated with the prison setting that require attention and potentially specific safeguards. Up to one third of inmates in federal and provincial prisons have mental disorders (Association des services de réhabilitation sociale du Québec 2015, 5). In federal prisons there is some access to psychiatric care, while in provincial prisons access is very poor. The conditions of daily life in detention can be very distressing, such as isolation and poor access to facilities for the maintenance of personal hygiene. These may contribute significantly to a person's suffering. These issues must be considered when assessing a request.

Specific safeguards could include not pursuing requests during the pre-trial period or at the beginning of a sentence when persons are highly distressed and at high risk of suicide. Greater collaboration between the relevant government branches will be required to ensure patients receive appropriate and timely care. Consideration should be given to creating a group of assessors equipped with the specialized knowledge of the prison setting, as well as MAID resource people in each institution or each region.

The question of whether MAID should be permitted for a person whose request is based on the wish to die to avoid serving a sentence (assuming the eligibility criteria are fulfilled) is a difficult one. This is a subject that requires more in-depth reflection for the next version of this document.

4.3.3 Persons whose requests for MAID MD-SUMC are refused

Persons who are considered ineligible to receive MAID after having undertaken the assessment process may continue to seek out mental healthcare and social support. Ideally, recommendations made during the assessment process will inform further care planning. We are particularly concerned that this group of persons is at risk for suicide as a result of being refused (NVvP 2018, 32; Isenberg-Grzeda et al. 2020). On the other hand, such persons may accept the refusal but have a continued need to speak about their wish to die, something which should continue to have a place within the therapeutic relationship.

Section 5. Final Remarks

5.1 REQUIRED RESOURCES

In order for MAID MD-SUMC to be practised in a manner that is humane, rigorous and fair, certain steps and resources must be undertaken concerning access to care, training for assessors and providers, and research.

As a group, persons with mental disorders experience greater socioeconomic hardship than the general population, particularly those most severely affected. Many are entirely dependent on the public healthcare system to access treatment and services. Furthermore, they often have a limited social network of people who can provide material support to complement healthcare services and advocate on their behalf when needed. As a result, they face enormous challenges accessing their fair share of healthcare resources compared to patients in other sectors. This problem originates at the funding envelope for healthcare services where mental healthcare receives less than its proportionate share in the global provincial healthcare budgets (Mental Health Commission of Canada, 2012, 126). Even access to primary mental healthcare can prove difficult and is highly variable, not only region to region, but neighbourhood to neighbourhood. As was the case with access to MAID in the AREOLC, we believe that access to MAID MD-SUMC must be accompanied by a societal commitment that all persons with mental disorders have timely access to primary mental healthcare. A MAID request ought not to be the method for securing appropriate care.

We believe that access to MAID MD-SUMC must be accompanied by a societal commitment that all persons with mental disorders have timely access to primary mental healthcare.

While psychiatrists are familiar with the issues discussed in this document, learning to apply them in practice is an urgent priority. A training program for those physicians who wish to be involved in these cases as assessors, providers, BRAMM-SM members, and future teachers must be developed and readily accessible. Educational leaders within the AMPQ membership together with the CMQ can emulate the excellent work done by the Royal Dutch Medical Association (KNMG) in their development of the SCEN program and create a program that is tailored to the specificity of Québec. The AMPQ could also develop a peer mentoring network to provide mutual support to MAID MD-SUMC assessors and providers, as well as providing a forum for the development of best practice in this area. This could for example, be folded into the existing online platform of the Communauté de Pratique—Groupe Interdisciplinaire de Soutien (CP-GIS).

The question of how to allocate resources between MAID requesters and the vast majority of patients with mental disorders who will not request MAID is a difficult one. Balancing the needs of those patients waiting for access to care while also securing access for ordinary and even exceptional care for MAID requesters and respecting a reasonable timeframe for the MAID assessment process poses a serious dilemma. We call for systemwide reflection and action on the question so as to

SECTION 5. FINAL REMARKS

Allocation of resources should not be done "at the bedside" on a case-by-case basis, but in a coordinated manner so as to foster fairness, transparency and accountability.

avoid disparate practices from area to area. Allocation of resources should not be done "at the bedside" on a case-by-case basis, but in a coordinated manner so as to foster fairness, transparency and accountability.

Finally, the Government of Québec should create a requirement for regular commissioned research on questions relating to the practice of MAID (including but not only MAID MD-SUMC) in the public interest. Investigator-driven enquiry can occur in parallel, but a government funded and mandated program of independent research will ensure that practice evolves and improves as a result of real experience. Cyclical research also serves as a form of oversight at a distance, offering a window into how the practice is functioning.

5.2 FUTURE REVISIONS

We consider this document to be the beginning of a conversation, rather than its end. There are several ways in which this guidance can be improved in future iterations.

We think that this document ought to be reviewed within five years, when some experience may have been accrued by patients, families, MAID assessors and providers, and other healthcare professionals involved with patients requesting MAID.[26] The revision process will ideally include a rigorous method to capture and report these experiences. It will also include the systematic review of relevant empirical research. Finally, attention should be paid to advances in philosophical and ethical analyses of central problems such as the understanding of suicide and the concept of incurability in mental health.

As the brief section on the prison setting indicates, greater reflection will have to be given to the difficult questions that arise in psychiatric sub-populations, particularly those who tend to request MAID. The specificity of patient groups relative to the eligibility criteria, as well as the ongoing needs of different types of requesters and of refused patients, will have to be better defined and integrated into revisions and training for those physicians who participate in MAID MD-SUMC practice.

Finally, efforts should be made to ensure that revisions include a diversity of voices and perspectives, particularly those of patients and significant others.

We consider this document to be the beginning of a conversation, rather than its end. There are several ways in which this guidance can be improved in future iterations.

[26] Even if the federal bill excluding MAID MD-SUMC becomes law, the issues discussed in this document will remain relevant to many MAID requesters who are not at the end of life. The discussion within this document as it applies to them should be updated.

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APPENDIX

Areas to be explored in MAID MD-SUMC assessments

All MAID evaluations should include a standard psychiatric evaluation, as well as a complete psychiatric functional enquiry, which may point to other areas of impairment or new diagnoses which had not previously been addressed and for which new therapeutic avenues can be suggested.

A standard evaluation includes minimally: a history of the presenting problem(s), past psychiatric, medical and legal history, history of substance use, current and past treatments, family medical and psychiatric history, and personal/social history.

In addition to the elements of a standard evaluation, there are several areas that ought to be carefully explored with a person requesting MAID. These aspects should be explored in meetings with the individual. These include, among others:

- Experience and duration of illness
- Circumstances in which the person has felt better and worse than at present
- Treatment experiences and relationships with providers
- Degree of functional impairment over time
- Elements that contribute to suffering
- Coping mechanisms and how these have evolved over time
- The extent to which the person's expectations of the future and degree of hope are realistic
- Bereavement and experience of loss
- History of trauma and abuse
- Personal relationships and relationship dynamics, including with family and significant others
- Socioeconomic circumstances
- Beliefs about death, including spiritual beliefs
- How and why MAID came to be seen as an option
- Decisional capacity
- Previous MAID requests, if any

Further information should be obtained by seeking collateral information from family, other clinicians involved in the patient's care, and as documented in the records of past treatment and care. Informed consent is required for these steps.

Assessors should also explore the relationship dynamics in the treatment from the points of view of the attending physician and other clinicians involved in the care of the person.

With the consent of the requester, a meeting with significant others should also be undertaken to consider relationship dynamics, as well as their attitudes towards the request.

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