

# Assisted Dying for Mental Disorders: Why Canada's Legal Approach Raises Serious Concerns

Alec Yarascavitch

Undergraduate Law Student

University of Toronto

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## **I. Introduction**

The Supreme Court of Canada lifted the criminal prohibition on assisted dying in 2015 with its landmark judgment in *Carter v Canada*.<sup>1</sup> In the wake of the decision, the appropriate boundaries for access to assisted dying have been a central point of contention. While many Canadians support assisted dying for patients facing the irreversible decline caused by a terminal physical illness, there remains considerable controversy surrounding whether patients with suffering from mental disorders alone should be afforded similar access to assisted dying. This essay explores current controversies surrounding assisted dying for individuals with mental disorders, and questions the wisdom and safety of the systematic reliance on physician judgment as the primary safeguard to protect vulnerable patients with mental disorders from the misuse of assisted dying. It is informed by experiences from Canada and abroad, evidence from clinical medicine and research, shifting patterns of physician practice, and evolving public opinion.

## **II. A survey of the landscape of assisted dying for mental disorders**

In *Carter*, the Court declared that the combined effect of the relevant criminal code provisions was unconstitutional insofar as it prohibited assisted dying for “a competent adult person who (1) clearly consents to 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.”<sup>2</sup> The preamble to *Carter* captures the Court’s concern that “people who are grievously and irremediably ill... may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can

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<sup>1</sup> *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331 at para 127. (*Carter*).

<sup>2</sup> *Ibid* at para 127.

suffer until she dies from natural causes. The choice is cruel.”<sup>3</sup> The Court specified that the scope of the judgment was only intended to respond to the circumstances of the case. It made no specific pronouncement about the status of mental disorders in the context of assisted dying, and provided no additional guidance on the relationship between the legal and medical concepts of mental disorders. Since *Carter*, the landscape of assisted dying in Canada has evolved considerably, and whether to permit assisted dying for suffering due to mental disorders alone has been hotly contested.

The Parliamentary Special Joint Committee on Physician Assisted Dying advised that the “grievous and irremediable” criterion should not exclude non-terminal medical conditions, including mental disorders.<sup>4</sup> However, Federal Bill C-14, which was passed by Parliament this year, does not accommodate assisted dying for mental disorders alone. The federal assisted dying law defines patients with suffering from a grievous and irremediable condition as those who are (1) in an advanced state of irreversible decline with (2) a reasonably foreseeable natural death from (3) a serious or incurable illness, disease, or disability that (4) causes enduring and intolerable physical or psychological suffering that cannot be relieved under conditions that they find acceptable.<sup>5</sup> While the presence of comorbid mental disorders is not a bar to assisted dying when these criteria are met, the requirements for severity, incurability, intolerability and proximity to end of life have the likely combined effect of precluding access by patients whose suffering is solely related to a mental disorder.<sup>6</sup>

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<sup>3</sup> *Ibid* at para 1.

<sup>4</sup> Medical Assistance in Dying: A Patient-Centered Approach. Report of the Special Joint Committee on Physician-Assisted Dying. 42<sup>nd</sup> Parliament, 1<sup>st</sup> Session. Feb, 2016. (Joint Committee).

<sup>5</sup> An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). S.C. 2016, c.3, 241.2(2).

<sup>6</sup> Medical Assistance in Dying. Government of Canada. Published online Dec, 2016.

Advocates for assisted dying for mental disorders often cite the principles of autonomy, freedom of self-determination, and respect for human dignity as core values in support of their position. There is no doubt that the process of assisted dying is more humane and compassionate than the unreliable, traumatic, and often violent options that are otherwise available to people with mental disorders who express a desire to die.<sup>7</sup> However, these urgent calls to relieve mental suffering through assisted dying must be tempered by caution because the stakes are high, and retrospective solutions to problems created by a hastily assembled system are unacceptable. From the ethical and moral perspectives of both medicine and the law, it is prudent to be wary of an approach that emphasizes autonomy and individualism at the expense of some of the most vulnerable and stigmatized members of society.

Critics of the federal law disagree that its criteria preclude mental disorders, noting that the psychological suffering caused by mental disorders is no less important or intolerable than any other suffering, and that mental illness is often incurable and can indeed lead to death.<sup>8</sup> For example, dementia and anorexia nervosa are both chronic conditions, where the inevitable result of dementia is death, and some patients have in fact died in severe cases of anorexia. Critics argue further that the presence of such a mental disorder does not necessarily preclude the ability to make medical decisions.<sup>9</sup> However, by the time patients reach the advanced stages of disease where death becomes reasonably foreseeable, the associated cognitive changes clearly impair decision-making capacity. This in turn calls into question the underlying validity of providing assisted dying in such contexts.

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<sup>7</sup> Downie J. Bouquets and brickbats for the proposed assisted dying legislation. *Policy Options*. Apr 20, 2016 (Downie); Appelbaum P. Physician-Assisted Death for Patients with Mental Disorders – Reasons for Concern. *JAMA Psychiatry*. 2016;73(4):325-326 (Appelbaum).

<sup>8</sup> Downie J, Dembo J. Medical assistance in dying and mental illness under the new Canadian law. *JEMH* 2016.

<sup>9</sup> *Ibid.*

These are not simply theoretical concerns. Evidence from the medical literature and the international experience suggests that there should be serious concerns about the implementation of assisted dying for mental disorders.<sup>10</sup> Psychiatric illnesses are importantly different from the terminal physical conditions with respect to which *Carter* was decided, and the issues they raise deserve careful consideration. Importantly, mental disorders can strongly influence the perception of suffering and impair the capacity to make decisions. Judgements that rely too heavily on the expertise of physicians and individual clinical evaluations may be inadequate safeguards. The nature of mental disorders makes capacity assessments particularly challenging, because they can affect the rational and emotional thought processes that influence decision-making. Negative emotions and social isolation can fuel a downward spiral of hopelessness that impairs psychological resilience until even routine tasks seem overwhelming. Moreover, the right to refuse treatment, and the inherent unpredictability of the course of mental illness and potential response to treatment make the threshold for intractability unclear. Furthermore, research has repeatedly demonstrated that informed consent practices are frequently inadequate, often missing essential components, such as confirming the patient's understanding of their condition or the risks and benefits of treatment.<sup>11</sup>

The international experience demonstrates that these challenges have led to concerning trends of permissive incrementalism, where the use of assisted dying for mental disorders has gradually expanded in scope to include patients with advanced dementia, which is characterized by severe neurocognitive impairment, and personality disorders, whose decisions making

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<sup>10</sup> Kim SYH, DeVries RG, Peteet JR. Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014 [published online Feb, 2016]. *JAMA Psychiatry*. (Kim).

<sup>11</sup> Chapter 39: Making Health Care Safer II: An updated critical analysis of the evidence for patient safety practices. *Evidence Reports/Tech Assess*, No. 211. Rockville (MD): Agency for Healthcare Research and Quality. Mar, 2013. (Making Healthcare Safer).

abilities are complicated by extreme emotional reactivity to environmental and interpersonal stress. As the boundaries of assisted dying for mental illness expand, we risk substituting assisted dying for effective psychosocial and psychiatric intervention because of the inadequate and inequitable state of mental health services in Canada. While each of these factors is concerning on its own, their cumulative effect raises serious concerns about the use of assisted dying for mental disorders. Law makers, in cooperation with physicians, must put in place limitations to ensure that assisted dying is available to those who need it, but also that it is never used inappropriately. However, suffering is an inherently subjective and personal experience, and while we strive to be empathetic and compassionate, we can never fully appreciate the suffering experienced by another person. Therein lies the ultimate contention.

### **III. Mental disorders affect thought processes, decision-making and perception of suffering**

The assisted dying debate necessarily focuses on the definition of “intolerable” and “irremediable” suffering, and typically approaches these concepts from the perspective of medical treatment failure. However, the subjectivity of the experience and the relationship between mental disorders and resilience reveal that other important inputs, such as emotional states, social conditions, and patient expectations, modulate the perception of suffering and influence decision-making. This understanding helps to inform the specific concerns around assisted dying for mental disorders.

While it is conceptually convenient to distinguish between physical and psychological suffering when discussing assisted dying, these two entities are clearly linked by the common physiological processes and psychological underpinnings that influence the perception of

suffering. Since the seminal work of Wall and Melzack on the gate control theory of pain,<sup>12</sup> research into the perception of pain has expanded our understanding well beyond transmission and modulation of physiologic signals. In the intervening fifty years, a considerable body of research recognizes the intrinsic link between physical and physiological suffering: all physical suffering is psychological, and psychological suffering often manifests as physical pain. From this perspective, simply drawing a line between physical disease and mental disorders fails to recognize their mutual and interdependent influence on the perception of suffering, and the inherent subjectivity of the experience. Indeed, the early Canadian experience with assisted dying has revealed that the majority of requests are motivated by the existential and psychological effects of a terminal diagnosis. While patients requesting assisted dying have terminal physical diagnoses, they routinely exhibit psychological symptoms characteristic of mental disorders, such as depression. Moreover, it is not the physical suffering that most patients find intolerable, but rather the prospect of losing control and dignity.<sup>13</sup> Of patients requesting assisted dying, those whose desire to die is rooted in existential and psychological distress are the ones who most often follow through.<sup>14</sup>

Resilience is a necessary trait that determines whether patients with a mental disorder improve. The effect of a mental disorder on cognition, behaviour and emotions influences an individual's capacity for resilience, which in turn affects whether the experience of suffering is perceived as either intolerable and irremediable. For example, the emotional disturbances in depression are the source of both suffering and lack of resilience. Failure to understand this

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<sup>12</sup> Melzack R & Wall P. Pain Mechanisms: A New Theory. *Science* 1965. New Series, Vol. 150, No. 3699, p.971-8.

<sup>13</sup> Personal communication with Dr. Danielle Kain, palliative care physician and provider of medically assisted dying at the University Health Network, University of Toronto. Ontario, Canada. Dec 16, 2016.

<sup>14</sup> *Ibid.*

relationship in turn neglects important opportunities to improve quality of life by remediating suffering to a point below the threshold of intolerability.

The emotional components of pain that are often equated with suffering and modulate its experience are often more important than the signal itself.<sup>15</sup> The centres of the brain that process emotions and respond to social rejection are also responsible for regulating physical pain, while serotonin, the neurotransmitter that is deficient in depression, influences the emotional response to pain.<sup>16</sup> Indeed, research suggests that depression causes pain at least as often as pain causes depression.<sup>17</sup> Moreover, depression is known to exacerbate physical pain<sup>18</sup> and treating depression can improve or even eliminate the associated pain.<sup>19</sup> Given the link between emotional processing and the perception of pain, it is unsurprising that the degree of suffering does not necessarily correlate with the extent of physical or psychological trauma.<sup>20</sup> Indeed, how a person perceives pain and suffering depends, in large part, on context.<sup>21</sup> Emotional states, such as fear, anxiety, and uncertainty exacerbate physical pain and the perception of suffering. Importantly, these emotional states are characteristically displayed by patients with mental disorders, such as depression, for which assisted dying is often proposed.

While mental disorders do not equate with incapacity, their potential impact on capacity and decision-making should not be ignored. Influence from emotions that are inappropriate,

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<sup>15</sup> Hansen G & Streltzer J. The Psychology of Pain. *Emerg Med Clin N Am* 2005. 23;339-48. (Hansen).

<sup>16</sup> Vastag B. Scientists find connections in the brain between physical and emotional pain. *JAMA* 2003;290(18): 2389-90.

<sup>17</sup> Merskey H. Psychological medicine, pain, and musculoskeletal disorders. *Rheum Dis Clin North Am* 1996;22(3):623-39; Atkinson JH, et al. Prevalence, onset, and risk of psychiatric disorders in men with chronic low back pain: a controlled study. *Pain* 1991;45:111-21.

<sup>18</sup> Fishbain DA. Approaches to treatment decisions for psychiatric comorbidity in the management of the chronic pain patient. *Med Clin North Am* 1999;83(3):737-60.

<sup>19</sup> Sternbach RA. Pain. A psychophysiological analysis. New York: Academic Press; 1968; Ferrari R. Prevention of chronic pain after whiplash. *Emerg Med J* 2002;19(6):526-30.

<sup>20</sup> Wall PD. On the relation of injury to pain. *Pain*, 1979; 6:253-64.

<sup>21</sup> Lambert WE, Libman E, Poser EG. The effect of increased salience of a membership group on pain tolerance. *J Pers* 1960;38:350-7.



disproportionate, or absent can severely distort the appreciation and rationality aspects of decision-making. This is often the case in depression, where patients burdened by hopelessness and apathy can be driven to make irrational and harmful choices. Pain and suffering can be improved by treating underlying emotional states and providing psychosocial support, such as improving a patient's sense of control and allowing them to participate in their own care.<sup>22</sup> However, these techniques are not routinely applied by medical practitioners, and the impact of emotional states on decision-making is often overlooked.

Expectations also influence the degree to which a person experiences suffering, their response to interventions, and the likelihood that the condition will become chronic or debilitating. Indeed, studies demonstrate that showing a person how other people have responded to a stimulus can affect their own experience to the same stimulus. For example, pain tolerance has been shown to increase more than three times after observing tolerant responses as compared to after observing hypersensitive responses.<sup>23</sup> Suffering experienced by patients is also strongly influenced by other psychological factors, including “what patients believe about their condition, their coping skills, their tendency to “catastrophize”, their self-efficacy, and sense of control.”<sup>24</sup> Moreover, comorbid medical conditions and issues related to psychological, legal and social factors influence the perception of suffering and the emotional capacity for resilience.<sup>25</sup>

In medicine, the failure of the health care system to protect individuals from harm when the intent is to help is colloquially described as “falling through the cracks.” With respect to assisted dying, failure to consider the impact of social factors and the effect of emotional changes

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<sup>22</sup> Hansen, *supra* note 15.

<sup>23</sup> Craig KD. Social modeling influences on pain. In: Sternbach RA, editor. The psychology of pain. New York: Raven Press; 1978. p. 73–110.

<sup>24</sup> Hansen, *supra* note 15.

<sup>25</sup> Weisberg MB, Clavel AL Jr. Why is chronic pain so difficult to treat? *Postgrad Med* 1999.

caused by a mental disorder on a patient's thought processes, rational decision-making abilities, and perception of "intolerable" suffering effectively substitutes the "crack" for a "chasm" into which countless patients are likely to vanish. Before concluding that suffering is intolerable and irremediable, deliberate attention must be paid to the non-medical factors that contribute to the experience. A therapeutic approach that is conscious of the influence of psychosocial factors on the perception of suffering has the potential to restore quality of life and reduce the need for assisted dying overall.

#### **IV. Definitions of "mental disorder" offer little guidance on where to draw the line**

As the Court in *Carter* did not explicitly address mental disorders, the subsequent debate about access to assisted dying for mental disorders lacks the benefit of a uniform legal definition. Across Canada, the variation in statutory definitions of "mental disorder" raise questions about the comparative understanding of mental illness from legal and medical perspectives. Surveying the various provincial mental health acts reveals that the legal definition of "mental disorder" differs considerably depending on the jurisdiction. For example, Alberta recognizes a connection between mental disorders and impaired capacity, where "mental disorder" means "any substantial disorder of thought, mood, perception, orientation or memory that grossly impairs: judgment, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life."<sup>26</sup> The definition in British Columbia is similar, but less specific. In that province, a mental disorder is defined as "seriously impair[ing] the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others."<sup>27</sup> Conversely, Ontario defines mental

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<sup>26</sup> Mental Health Act, R.S.A. 2000, c. M13. s.1(1)(g)

<sup>27</sup> Mental Health Act, R.S.B.C 1996, c. 288. Part 1 s.1.

disorder simply as “a disease or disability of the mind,” which is unhelpful in its breadth.<sup>28</sup>

Unfortunately, the *Criminal Code of Canada* presents a similarly broad definition, although its application is narrowly confined to the accused’s understanding of right and wrong as it relates to the defense of “not criminally responsible on account of mental disorder.”<sup>29</sup>

These various statutory definitions through which mental disorders attract special legal attention provide little guidance for determining the appropriate boundaries that would apply if assisted dying is permitted for mental disorders. Moreover, in some circumstances, the criteria that give legal effect to a mental disorder, such as those in Alberta, reflect impairments of the fundamental requirements for a patient to be deemed capable of making treatment decisions. This apparent discord necessitates more clearly articulated and harmonious legal concepts of mental disorders across jurisdictions, and of capacity in the context of mental illness, which can be a complex endeavor. If assisted dying is allowed for mental disorders strictly based on these legal definitions, application in Ontario would be very broad, while those in Alberta would arguably not qualify based on incapacity. Such unequal treatment under the law would clearly be unacceptable. In practice, legal definitions are necessarily informed by medical assessments and the judgment of practitioners who operate with a different and more nuanced understanding of mental illness. Indeed, the Court in *Carter* placed considerable emphasis on the expertise of physicians, and medical practitioners operating within the constraints of legal criteria will necessarily guide the application and evolution of assisted dying. However, if criteria for proximity to end of life are removed, and assisted dying is to be permitted for mental disorders, it is unclear where to draw the line.

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<sup>28</sup> Mental Health Act, R.S.O. 1990, c. M.7. s.1(1)

<sup>29</sup> Criminal Code, R.S.C., 1985, c. C-46. s.2. vaguely defines mental disorder as “a disease of the mind.”

## V. Collective experience suggests that the slope is slippery

Some form of assisted dying is now legal in Canada, several European countries, and seven US states, with a further 26 states set to consider assisted dying in the coming year.<sup>30</sup>

While laws in Canada and the US limit assisted dying to patients near the end of life, some European countries, such as Belgium and the Netherlands, have enacted more permissive assisted dying regimes that include patients who suffer solely from mental disorders.<sup>31</sup>

While the Court in *Carter* was presented with evidence that “[o]nce euthanasia is allowed, it becomes very difficult to maintain a strict interpretation of the statutory conditions,”<sup>32</sup> the Court was unconvinced that a “slippery slope” would develop in Canada. In the Court’s view, countries that had permitted assisted dying had successfully instituted safeguards to protect vulnerable populations. Moreover, the Court emphasized its confidence in the judgment of individual physicians to ensure that no person who is ineligible for assisted dying would receive it. However, the response in Canada since *Carter* and the cumulative international experience suggest that incremental changes in accepted societal norms, public opinion, and physician practice patterns threaten to expand the scope of assisted dying beyond the Court’s contemplation.

There have been several unexpected developments in the short time since *Carter* was decided and the subsequent federal legislation was enacted. The demand for and use of assisted dying in Canada has already exceeded initial projections. In Quebec, which preempted the Supreme Court with its own provincial assisted dying law in 2014, government forecasts

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<sup>30</sup> Death With Dignity National Center. Death with dignity around the U.S. <http://www.deathwithdignity.org/advocates/national>. Accessed Nov 1, 2016. (Death With Dignity).; *Appelbaum*, *supra* note 7.

<sup>31</sup> *Appelbaum*, *supra* note 7.

<sup>32</sup> *Carter*, *supra* note 1 at para 111.

suggested that approximately 100 patients would obtain assisted dying in the first year.<sup>33</sup> However, as of December 2016, 461 patients had received assisted dying, which is over four and a half times the number that was initially estimated.<sup>34</sup> Moreover, the scope of the discussion has expanded well beyond the terminal physical illness context in which the case was argued. In the year following *Carter*, the Report from the Special Joint Committee on Physician Assisted Dying recommended a much more permissive regime that would allow access to assisted dying for mental disorders and mature minors, neither of which were directly addressed in the judgment.<sup>35</sup> Some critics of the federal legislation have even argued that the new law “falls below the bare minimum” required by the Court.<sup>36</sup> In light of this commentary, it is clear that the boundaries of Canada’s new assisted dying law will be challenged. It has never been a question of whether this would happen, but only when.

Even before end of the suspension period set by the Supreme Court, Canadians with mental illness voiced their intent to seek assisted dying.<sup>37</sup> Indeed, in 2016, the Alberta Court of Appeal unanimously approved the assisted dying request for a woman suffering from conversion disorder, a non-terminal mental disorder that causes unexplained physical symptoms.<sup>38</sup> In its judgment, the court distinguished between the psychological and physical experience of suffering, emphasizing that the physical pain caused by the patient’s mental disorder was distinct from the psychological and emotional suffering seen in other mental disorders, like depression.<sup>39</sup> These developments following *Carter*, and the international experience with assisted dying for

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<sup>33</sup> Peritz I. Quebec’s assisted-death requests to top 300 by 2017. *The Globe and Mail Online*. Oct 27, 2016.

<sup>34</sup> Gentile D. Over 450 Quebec patients received medical aid in dying last year. *CBC News Online*. Mar 14, 2017.

<sup>35</sup> *Joint Committee, supra* note 4.

<sup>36</sup> *Downie, supra* note 7; *Appelbaum, supra* note 7.

<sup>37</sup> Carreiro D. Winnipegger seeks physician-assisted death for depression. *CBC News Online*. Feb 2, 2016.

<sup>38</sup> Gaid K. How mental illness complicates medically assisted dying. *The Globe and Mail Online*. May 30, 2016.

<sup>39</sup> *Canada (Attorney General) v E.F.* 2016 ABCA 155. (EF).

mental disorders, raise doubts about the Court’s confidence in cultural factors and medical judgment as effective safeguards.

## **VI. The law relies on physicians as gatekeepers to protect the vulnerable**

Advocates for assisted dying in the context of mental disorders often assume that physician judgment is an adequate safeguard for protecting vulnerable patients. They base their argument on an implicit trust that individual expertise is a satisfactory bar to inappropriate access. Indeed, the Court’s reasoning in *Carter* reflects the commonly held assumption that physicians can accurately and reliably determine whether a patient with a mental disorder has an intractable condition, whether they possess adequate capacity to consent to assisted dying, whether their mental disorder causes them to be vulnerable, and whether that vulnerability is unduly affecting their request for assisted dying.

The concept of vulnerability was a recurrent theme throughout *Carter*. The Court found that “the object of the [criminal] prohibition [was]... to protect vulnerable persons from being induced to commit suicide at a time of weakness.”<sup>40</sup> While the Court concluded that this was a valid goal, it ruled that the infringement on s.7 *Charter* rights was overbroad. Central to this determination was the view that “vulnerability can be assessed on an individual basis, using procedures that physicians apply in their assessments of informed consent and decisional capacity in the context of medical decision-making more generally.”<sup>41</sup> The Report of the Special Joint Committee on Physician-Assisted Dying has since expressed similar faith in the ability of

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<sup>40</sup> *Carter*, *supra* note 1 at para 84.

<sup>41</sup> *Ibid* at para 115.

healthcare professions to develop appropriate guidelines.<sup>42</sup> Additionally, physician opinion is prominently featured among the safeguards enumerated in the federal law.<sup>43</sup>

Beyond the expression of confidence in physicians' abilities, the Court did not engage with the substance of the government's concern that "cognitive impairment, depression or other mental illness, undue influence, psychological or emotional manipulation, systemic prejudice, and the possibility of ambivalence or misdiagnosis may escape detection or lead to errors in capacity assessments."<sup>44</sup> However, the experience in Belgium and the Netherlands, the practical difficulties in assessing capacity and intractability, and the current practices for informed consent suggest that assisted dying for mental disorders should be approached with extreme caution, if it is to be permitted at all.

## **VII. The international experience with assisted dying for mental disorders raises concerns**

Data suggests that suffering due to mental disorders accounts for about 1% and 3% of assisted dying requests in the Netherlands<sup>45</sup> and Belgium,<sup>46</sup> respectively. The prototypical scenario presented in favour of assisted dying for mental disorders involves enduring and intolerable psychological suffering due to severe, treatment-resistant depression. Depression is the ideal exemplar because it is the most commonly encountered mental disorder, and is often associated with chronic physical pain.<sup>47</sup> Supporters describe a compelling narrative of intractable hopelessness and despair without any reasonable prospect of recovery despite aggressive

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<sup>42</sup> *Joint Committee, supra* note 4.

<sup>43</sup> An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), S.C. 2016, c.3, 241.2(3)(a).

<sup>44</sup> Carter, *supra* note 1 at para 114.

<sup>45</sup> *Death With Dignity, supra* note 30.

<sup>46</sup> Thienpont L et al. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*. 2015;5(7):e007454. (Thienpont).

<sup>47</sup> Means-Christensen AJ et al. Relationships among pain, anxiety, and depression in primary care. *Depression and Anxiety*, 2008;25;593-600.

treatment, and legitimate complaints of physical pain either derived from or exacerbated by the underlying mood disorder. However, this limited view overlooks problems that arise when assisted dying criteria are interpreted more liberally as to encompass a broad spectrum of mental disorders. The Diagnostic and Statistical Manual of Mental Disorders contains hundreds of conditions, each with their own range of symptoms, spectrum of severity, and potential to cause suffering. It is unclear where to draw the line if it is the intractable and intolerable suffering itself that is important rather than its source. Indeed, evidence does not support the common assumption that only patients with treatment-refractory mental disorders that align with models for physical disease processes will receive assisted dying.

In countries where assisted dying is permitted for mental disorders, the scope of eligible mental conditions has gradually expanded well beyond severe depression.<sup>48</sup> Reports from Belgium and the Netherlands show that assisted dying has been provided to patients with a wide variety of mental disorders, including dementia, schizophrenia, obsessive-compulsive disorder, conversion disorders, post-traumatic stress disorder, personality disorders, and severe eating disorders.<sup>49</sup> Assisted dying has even been provided for a transgendered Belgian patient whose gender dysphoria persisted despite sex reassignment surgery.<sup>50</sup> Transgendered people constitute a highly vulnerable and marginalized group, and rationalization for assisted dying in these circumstances is more difficult than for depression. In addition, a retrospective examination found that a significant proportion of cases where assisted dying was provided for mental disorders did not involve depression (25%), while several were complicated by comorbid

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<sup>48</sup> Berghmans R, Widdershoven G, Widdershoven-Heerding I. Physician-assisted suicide in psychiatry and loss of hope. *Int J Law Psychiatry*. 2013;36(5-6):436-443; Schuklenk U, van de Vathorst S. Treatment-resistant major depressive disorder and assisted dying. *J Med Ethics*. 2015;41(8):577-583.

<sup>49</sup> *Thienpont, supra* note 46; *Kim, supra* note 10.

<sup>50</sup> Hamilton G. Terminally transsexual: concerns raised over Belgian euthanized after botched sex change. *National Post Online*. Nov 22, 2013. (Hamilton).



psychiatric conditions, including substance abuse (9%), neurocognitive impairment (6%), and autism spectrum disorder (3%).<sup>51</sup> Furthermore, as many as half of Belgian and Dutch cases of assisted dying for mental illness were complicated by concurrent personality disorders, conditions which are characterized by emotional lability, turbulent relationships, and disproportionately intense responses to environmental and interpersonal stress.<sup>52</sup> These features and the associated pattern of relapsing-remitting self-harm ideation raise concerns about whether the desire to die is sufficiently stable to support a request for assisted dying.<sup>53</sup> The potentially transient nature of intent is exemplified by the finding that nearly 40% of requests for assisted dying for mental disorders were withdrawn.<sup>54</sup> At the crux of this issue is the difficult clinical delineation between suicidal ideation and a desire for an assisted death that reflects both valid consent for assisted dying and meets the criteria at law. Since suicidal ideation is considered by the medical community to be a temporary irrational state rather than an unchanging rational response to an unendurable situation, it becomes an imperative for consent to be able to distinguish between these two circumstances. While obligatory waiting periods and routine reevaluation intervals have been proposed as potential solutions, this finding raises doubts about whether the suffering experienced by patients who have received assisted dying was truly irremediable according to current Canadian law.

There is growing acceptance among physicians that the prospect of psychological “death” before physical death can be intolerable. Evidence from the Netherlands also suggests that a cultural shift in physician attitudes in favour of assisted dying for mental disorders, and corresponding changes in practice patterns may have the effect of creating a more permissive

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<sup>51</sup> *Kim, supra* note 10.

<sup>52</sup> *Appelbaum, supra* note 7.

<sup>53</sup> *Ibid.*

<sup>54</sup> *Appelbaum, supra* note 7; *Thienpont, supra* note 46; *Kim, supra* note 10.

regime over time. Requests related to neurocognitive disorders, such as dementia, present particular difficulties because the patient's progressive decline inevitably impairs the ability to make decisions. This raises obvious concerns about whether such patients can qualify because of the inherent challenges of assessing capacity in dementia, such as the fluctuating effect on cognition and lucidity, and the phenomenon of confabulation, through which patients can project a convincing display of competence despite failing standard tests for comprehension and cognitive function. Still, a 2010 survey of physicians who provide assisted dying services found that 17% believed dementia could be a valid reason for terminating life.<sup>55</sup> By 2015, this number had more than tripled, with nearly half of Dutch physicians stating that they would be willing to provide assisted dying for dementia.<sup>56</sup> A third even supported this idea for cases of advanced neurocognitive decline in the presence of a clear advance directive. This cultural shift corresponds to an increase in the use of assisted dying for dementia, which more than doubled during that period of time and now accounts for 1 in 50 cases of assisted dying in the Netherlands.<sup>57</sup>

Current Canadian law explicitly excludes advanced directives and substitute decision-making for assisted dying, yet polls suggest that 8 in 10 Canadians support the right to advanced consent for assisted dying.<sup>58</sup> Accordingly, the evolving Dutch experience demonstrates that the use of advance directives relating to mental disorders is not inconceivable.<sup>59</sup> Dutch law has

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<sup>55</sup> de Boer MR et al. Advance directives for euthanasia in dementia: do law-based opportunities lead to more euthanasia? *Health Policy* 2010; 98(2-3):256-62 (de Boer)

<sup>56</sup> Bolt EE et al. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living? *J Med Ethics* 2015;41:592-8

<sup>57</sup> Netherlands – 2015 Euthanasia Report Card. Dying for Choice. May, 2016.

<sup>58</sup> Groundbreaking poll: 8 in 10 Canadians support the right to advance consent for assisted dying. Dying with Dignity Canada. Published Online, Feb, 2016.

<sup>59</sup> de Boer, *supra* note 54.

allowed the use of advance directives for assisted dying since 2002,<sup>60</sup> and patients with advanced dementia have in fact received assisted dying where they had “for years been discussing... their desire to terminate their lives if their suffering became unbearable.”<sup>61</sup> This is problematic because it places even greater importance on the expertise and judgment of physicians, who not only need to determine issues of capacity, irremediableness, and vulnerability, but now also need to make an objective assessment of whether the patient is experiencing suffering that reaches the threshold of subjective intolerability before executing the advance directive. Such reliance puts vulnerable patients with mental disorders at even greater risk.

### **VIII. Capacity assessments in practice are less reliable than assumed**

Capacity to make decisions is a fundamental concept in both medicine and law, and critically important in the context of assisted dying.<sup>62</sup> To consent to treatment, a person must be capable of understanding the relevant information and appreciate the reasonably foreseeable consequences of their decision.<sup>63</sup> Capacity is generally presumed unless there are reasonable circumstances to suggest otherwise.<sup>64</sup> Canadian law does not accept global assessments of decision-making capacity, but rather approaches capacity as a mutable quality related to the specific activity in question at the specific time of assessment.<sup>65</sup> This makes the task of practitioners challenging, because not all decisions require the same degree of capacity, and capacity can change over time. A patient may lack capacity for one decision, but be competent

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<sup>60</sup> *Ibid.*

<sup>61</sup> Regional Euthanasia Review Committees. Annual Report 203. The Hague, 2014.

<sup>62</sup> Charland C, Lemmens T, & Wada K. Decision-making capacity to consent to medical assistance in dying for persons with mental disorders. JEMH 2016:2. (Charland).

<sup>63</sup> Consent to treatment. Policy 3-15. College of Physicians and Surgeons of Ontario. May 2015; Health Care Consent Act, S.O. 1996, c. 2, Sched. A, s.4(1). (CPSO Policy 3-15).

<sup>64</sup> Health Care Consent Act, S.O. 1996, c. 2, Sched. A, s.4(2) to (3).

<sup>65</sup> Gilmour J. Legal Capacity and Decision Making in Downie J, Caulfield T & Flood C, Canadian Health Policy (p. 357). LexisNexis Canada Inc, 2011.

for another, and their status with respect to either decision may fluctuate depending on when it is assessed.<sup>66</sup> This means that determining whether a patient has the capacity to refuse treatment and the capacity to consent to assisted dying need to be assessed independently because they do not necessarily have the same answer. However, the practical means by which physicians commonly determine capacity suggests that these questions are often not separated.

How capacity is assessed in practice varies among physicians, and the subjectivity introduced by clinical judgment and biases can lead to different determinations in the same case. The general assumption by courts is that doctors can accurately determine medical futility and decisional capacity in the context of mental disorders, with the implication that no ineligible person would receive assisted dying. However, in practice, the assessments in which assisted dying advocates and courts put their faith are highly subjective and lack rigorous thresholds. Indeed, the Court in *Carter* relied in large part on the “procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally”<sup>67</sup> to conclude that “a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error.”<sup>68</sup> However, concerns related to capacity assessments suggest that broadening access criteria poses a significant threat to patients with mental disorders.<sup>69</sup>

The MacArthur Treatment Competence Assessment Tool is generally considered to be the gold standard for capacity assessments.<sup>70</sup> It tests a patient’s ability to express choice, their understanding of the facts related to the decision, their appreciation of those facts and the

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<sup>66</sup> *Ibid.*

<sup>67</sup> Carter, *supra* note 1 at para 115.

<sup>68</sup> *Ibid* at para 105.

<sup>69</sup> Kim SH, Lemmens T. Should assisted dying for psychiatric disorders be legalized in Canada? *CMAJ* 1016. (Lemmens).

<sup>70</sup> Appelbaum P & Grisso T. Assessing patients’ capacities to consent to treatment. *NEJM*,1998;319(25), 1635-1638.

decision, and how they rationally weigh the facts and the consequences.<sup>71</sup> While the MacArthur tool is often used in research and has been modified for use in the legal field, it is not generally applied by physicians in routine practice. The screening tools more commonly available to clinicians, the Mini-Mental State Examination and Montreal Cognitive Assessment (MoCA), reflect only global cognitive capacity, rather than separate dimensions. However, capacity assessments that do not consider decisional abilities independently often miss subtle deficits that can render a patient incapable.<sup>72</sup> For example, research suggests that when decisional abilities are considered separately, the prevalence of incapacity is greater than expected in patients who show no overt signs of cognitive impairment.<sup>73</sup> Furthermore, neither of these commonly used tests reflect capacity as it relates to a specific decision at a specific time, which is not consistent with either best practices or Canadian legal requirements. In the wake of legalized assisted dying, palliative care specialists have begun to respond to this concern by adopting alternative assessment tools that better capture the patient's understanding of the specific decision at hand, such as the Aid to Capacity Evaluation.<sup>74</sup> However, none of these objective assessment tools examine emotional capacity, a factor that has important influence on the "intolerability" of suffering, the reasonableness of thought processes, and the clarity of decision-making. In order to give effect to the Court's confidence in physician expertise as the primary protection against the misuse of assisted dying for mental disorders, the medical community must be thoroughly educated on the legal requirements and optimum tools for capacity assessments to create a lasting cultural shift in physician practices.

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<sup>71</sup> *Ibid*

<sup>72</sup> Gurrera RJ et al. Neuropsychological performance within-person variability is associated with reduced treatment consent capacity. *Am J Geriatr Psychiatry* 2014;22(11); 1200-9.

<sup>73</sup> *Gurrera, supra* note 71.

<sup>74</sup> Aid to Capacity Evaluation (ACE). Joint Centre for Bioethics. University of Toronto. 2016.

Retrospective reports from Belgium and the Netherlands reveal that most assessments for assisted dying for mental disorders have been expressed as a global determination without objective evidence, raising questions about the rigor of assessment and application of strict criteria.<sup>75</sup> While the presence of a mental disorder is not evidence of incapacity, some patients who request assisted dying for a mental illness will obviously fail to meet the requirements, such as patients with active psychosis.<sup>76</sup> However, there are many conditions that increase the risk of incapacity, such as depression, intellectual disability, and dementia, but their effect on decision-making may not be readily apparent.<sup>77</sup>

Despite the availability of objective assessments, physicians in practice typically determine capacity using a clinical gestalt assessment, which is both highly subjective and variable. Indeed, such individual clinical judgment is supported by the language of provincial health statutes and the federal assisted dying law.<sup>78</sup> Subsequent guidance from medical regulatory authorities simply affirms that the criteria for capacity remain unchanged in the context of assisted dying.<sup>79</sup> Clinical judgment supports the values of respect for individuality and patient centered care, and has the potential benefit of examining emotional capacity, but it strongly favours subjective opinion over objective measures, which leads to unacceptable variability, especially in difficult cases.<sup>80</sup>

While psychiatrists are arguably the best equipped to reliably assess capacity in the context of mental disorders, the international experience with the use of clinical expertise to

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<sup>75</sup> Lemmens, *supra* note 68.

<sup>76</sup> Price A. Mental capacity as a safeguard in assisted dying: Clarity is needed. *BMJ* 2015;351:h4461.

<sup>77</sup> Lemmens, *supra* note 68.

<sup>78</sup> Ontario's Mental Health Act and Health Care Consent Act, and Federal Bill C-14 all refer to whether a patient meets criteria "in the opinion of" the attending physician.

<sup>79</sup> Medical Assistance in Dying. Policy 4-16. College of Physicians and Surgeons of Ontario. Jun, 2016. (CPSO Policy 4-16).

<sup>80</sup> This is exemplified by the legal standard for capacity: "of the opinion that the person is capable with respect to the treatment, and the person has given consent."; Charland, *supra* note 83.

adjudicate requests for assisted dying for mental illness is troubling. For example, in the Netherlands, a panel of three independent physician reviewers disagreed about whether the patient was competent in one quarter of requests for assisted dying due to a mental disorder.<sup>81</sup> This brings into question the reliability of the Canadian model, which readily accepts the opinion of individual physicians. In addition, it is uncertain how accurately a non-psychiatrist, and therefore non-specialist physician can assess the intractability of a mental disorder. General medical training pays little attention to the methods and skills for determining capacity.<sup>82</sup> General practitioners, who are presently the primary means of accessing assisted dying in Canada, receive little more than basic instruction in general capacity assessments, and even less in the context of mental disorders.<sup>83</sup> Moreover, they may have quite different views on whether a condition is amenable to treatment. A physician's past clinical experiences and internal biases toward mental illness or assisted dying are therefore likely to influence their opinion of whether a patient is capable. Even psychiatrists, who are experts, are not immune to such bias.<sup>84</sup> Furthermore, most assisted dying access in Canada is facilitated through family physicians, and the doctor performing assisted dying is unlikely to have had a previous treatment relationship with the patient given the relatively small number of providers.<sup>85</sup> The practicalities of access mean, somewhat ironically, that the physicians with the least expertise and shortest therapeutic relationship with the patient are empowered to implement the law and adjudicate requests. This dissociation of expertise in assisted dying and expertise in capacity assessments in the context of mental disorders is clearly problematic. In addition, the vague legal criteria for capacity

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<sup>81</sup> *Kim, supra* note 10.

<sup>82</sup> Seyfried L, Ryan KA, Kim SY. Assessment of decision-making capacity: views and experiences of consultation psychiatrists. *Psychosomatics* 2013;54:115-23.

<sup>83</sup> *Ibid.*

<sup>84</sup> *Charland, supra* note 83.

<sup>85</sup> *Appelbaum, supra* note 7.

assessments that inherently rely on individual clinical judgment, and the finality of assisted dying make it challenging to hold doctors accountable for poor quality assessments.<sup>86</sup>

### **IX. Informed consent practices are inadequate in general**

Decision-making capacity is a precondition to informed consent, which has a prominent role in assisted dying because of the serious and irrevocable nature of the act. Valid consent necessarily requires that physicians provide patients with the information that a reasonable person in their position would want to know about the nature of the treatment, its expected benefits, its material risks and side effects, alternative courses of action and the likely consequences of not having the treatment.<sup>87</sup> Canadian medical regulatory colleges advise physicians that standard consent procedures apply for assisted dying.<sup>88</sup> The conversation may remain largely unchanged when the goal is to hasten the foreseeable death of a person who is terminally ill and facing inevitable physical decline. However, it is conceptually more difficult to reconcile the expected benefit of premature death with the case of a patient who is physically well, but is struggling with a mental disorder.

The inverse intentions and finality of assisted dying make the conversation fundamentally different, especially if the patient has the right to refuse treatment options that could remediate the condition. Mental disorders are complex in that determining the endpoint at which all therapeutic options have been exhausted is necessarily subjective. For example, the maximum allowable lifetime dose for cancer radiation therapy is objectively determined according to patient characteristics, such as gender, weight, and age. Further radiation therapy is no longer an option once this personalized threshold is reached. However, there is no such objective endpoint

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<sup>86</sup> *Lemmens, supra* note 68.

<sup>87</sup> *CPSO Policy 3-15, supra* note 63, s.11(2) to (3).

<sup>88</sup> *CPSO Policy 4-16, supra* note 79.



for cognitive behavioural therapy (CBT), which is a non-invasive treatment commonly used in depression and personality disorders. Moreover, CBT is a long-term treatment that is often slow to produce results, but has clear cumulative benefit without any side effects. This kind of situation creates ethical tension between the right to refuse care that offers clear benefits with little risk, and the validity of informed consent in the context of assisted dying. It is difficult to comprehend how a reasonable person in this situation who has good prospects of improvement would instead choose to die, raising the question of whether the patient accurately understood the material risks and benefits at all.

Research demonstrates that, despite the legal requirements for informed consent, the routine consent discussions in which physicians engage with patients are often inadequate. This suggests that the Court's faith in current informed consent practices may not be justified. Studies on the content of consent have revealed that 45-91% of informed consent discussions fail to include all the elements of a valid consent.<sup>89</sup> The most common missing element is an assessment of patient understanding, which is a fundamental part of the process.<sup>90</sup> In addition, studies examining patient understanding have repeatedly found that most patients are unable to recall or do not adequately understand most of the information provided to them during the informed consent discussion.<sup>91</sup> Moreover, evidence suggests little association between what physicians report telling patients and what patients report as their understanding and expectations.<sup>92</sup> Given that capacity necessarily depends on the ability to understand, assess and rationally weigh the facts and consequences, the lack of patient understanding about the intervention raises the question of whether capacity was adequately assessed by clinicians at the

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<sup>89</sup> *Making Healthcare Safer*, *supra* note 11.

<sup>90</sup> *Ibid.*

<sup>91</sup> *Ibid.*

<sup>92</sup> *Ibid.*

time of consent. While such errors are concerning for the adequacy of consent in general, they are unacceptable in the context of assisted dying given the finality of the decision.

#### **X. The right to refuse treatment is problematic in the context of mental disorders**

The Court in *Carter* qualified its use of the word “irremediable” as not requiring a patient to undergo any “treatments that are not acceptable to the individual.”<sup>93</sup> This caveat supports the general principle of autonomy, and makes sense from the perspective of a terminally ill patient who declines to undergo a treatment that trades quality of life for a short extension of life. Indeed, this is often a point of discussion in end of life care. However, the right to refuse treatment presents problems in the context of mental disorders. “Irremediable” does not simply mean that the condition must be chronic or incurable, but also suggests no prospect of improvement. This criterion, which is inherently vague, can only be given effect through substantial reliance on the individual clinical judgment of the treating physician. However, the range of options offered to a patient and the way in which they are presented can influence the patient’s choice, and the lack of clear guidance and transparency in clinical decisions puts vulnerable patients at risk.

While many mental disorders are incurable, they are not terminal. They often follow a relapsing-remitting course that is challenging, if not impossible to predict, and their severity and chronicity can only be assessed retrospectively, after successive trials of treatment and longitudinal observation. For example, bipolar disorder is life-long, but episodes are cyclical, and their frequency and duration are unpredictable. Yet, this disorder can be managed with medications. The right to refuse treatment obscures the ability to determine whether a case is irremediable, and raises strong doubts about whether there is any such threshold. It is unclear

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<sup>93</sup> Carter, *supra* note 1 at para 127.

whether a person who lives a normal, productive life interspersed by occasional episodes of decompensation would qualify for assisted dying if the cyclical nature of their condition causes them “intolerable” suffering.

Even severe cases of mental disorders have the potential to be remediated through appropriate intervention.<sup>94</sup> For example, evidence shows that most patients who have been diagnosed with treatment-resistant depression can achieve persistent remission if provided with intensive, personalized treatment in a specialized tertiary care centre.<sup>95</sup> It is concerning that competent patients with good prospects of remission could refuse reasonable treatment options, and instead choose to have their life ended by a medical professional. Evidence suggests that this is more than just a theoretical concern. In the Netherlands, 56% of patients who received assisted dying for mental disorders refused at least one recommended treatment, 20% had no history of psychiatric hospitalization, and the physician review panel disagreed about whether there was a reasonable prospect of improvement in nearly 25% of cases.<sup>96</sup> Moreover, the attending psychiatrist did not believe the requirements for incurability were met in 12% of cases, but assisted dying was still provided.<sup>97</sup> This is precisely the kind of potential safeguard failure that critics of assisted dying for mental disorders fear. Even with the restrictions put in place by Canada’s federal dying law, Canada is not immune to such failures. Indeed, the Alberta Court of Appeal had no trouble granting a request for assisted dying by a person with a conversion disorder even though the psychiatrist who supported the request had never met the applicant.<sup>98</sup>

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<sup>94</sup> *Joint Committee, supra* note 4.

<sup>95</sup> Fekadu A, Rane LJ, Wooderson SC, et al. Prediction of longer-term outcome of treatment-resistant depression in tertiary care. *Br J Psychiatry* 2012;201:369-75.

<sup>96</sup> *Appelbaum, supra* note 7; *Kim, supra* note 10.

<sup>97</sup> *Kim, supra* note 10.

<sup>98</sup> *Gaind, supra* note 38; *EF, supra* note 39.

Questions about the severity of illness and thoroughness of the evaluation raise obvious concerns about the wisdom of relying on physicians as the key safeguard for assisted dying.

## **XII. Poor access to mental health care puts vulnerable patients at risk**

Whether a mental disorder is irremediable is often viewed from a medical treatment perspective alone. However, social determinants of health importantly influence the degree of suffering associated with a mental disorder, but these are often inadequately addressed and sometimes not considered at all.<sup>99</sup> A permissive regime that allows assisted dying for mental disorders is not only premature, but puts a large category of marginalised and stigmatized people at risk.<sup>100</sup> Patients with mental disorders are vulnerable, not only because of their conditions, but also because of the poor socioeconomic conditions that often accompany psychiatric illness. Indeed, half the Dutch cases of assisted dying for mental conditions noted social isolation or loneliness as important contributing factors.<sup>101</sup> It is interesting that these aspects were specifically noted in the physicians' reports, because neither social isolation nor loneliness are convincingly incurable states.

Central to the issue of the remediation of mental disorders is access to care. Remediation is only possible if these services exist and are fully embedded into a patient-centered therapeutic regime. However, it is well established that the provision of mental health care and social supports for Canadians with mental disorders are inadequate and inequitable. Access, continuity and quality exhibit significant geographic variation, and are poorly integrated with the remainder

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<sup>99</sup> *Joint Committee, supra* note 4.

<sup>100</sup> *Lemmens, supra* note 68.

<sup>101</sup> *Kim, supra* note 10.

of the health system.<sup>102</sup> These failings of our mental health system contribute to and perpetuate the vulnerability of patients with mental disorders. The focus on tertiary care in Canada has led to a system of revolving door psychiatric care where some patients who are suffering from an acute mental health crisis are briefly stabilized in hospital, then discharged to communities that lack the resources to meet their needs. Patients who do not have adequate supports but require frequent care often have no other option but to visit local emergency departments when they inevitably decompensate. Rather than being greeted with care or compassion, their frequent presentations are often met with a collective sigh of frustration and attitude of dismissal, which diminishes the patient's feelings of self-worth during a time of need, and further marginalizes an already vulnerable and stigmatized group.

The poor state of our mental health system has eroded the core values of empathy and compassion that define medicine. We must be particularly cautious from this perspective, because the ability to empathize and be compassionate toward those with mental disorders is necessary for physicians to fulfill the duty entrusted to them as gatekeepers of assisted dying. It is unwise to enact a policy that permits assisted dying for mental disorders before providing adequate basic support services for patients with mental disorders, because in doing so we risk substituting assisted dying for effective psychosocial and medical intervention.

## **XII. Conclusion**

Assisted dying in Canada is in its infancy. It has been just a year since the declaration from *Carter* came into effect, and a federal law was crafted to fill the void. However, critics of the federal assisted dying law argue that it is too restrictive, and that assisted dying should be

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<sup>102</sup> This is especially true in Ontario, where the Ministry of Health and Long-Term Care has proposed changes through the *Patients First Act*, with the specific intention of targeting integration and equity within the province's mental health services.

permitted for suffering due to mental disorders. Advocates argue that the core values of autonomy, freedom of self-determination, and respect for human dignity at the core of the *Carter* judgment apply equally to mental and physical disorders, and that it is the intractable and intolerable nature of the suffering itself that is important, rather than the source. Indeed, the clear interdependency between physical and mental suffering makes them impossible to separate. However, patients with mental disorders are a stigmatized and vulnerable group, and we must be careful not to let individual autonomy interests eclipse societal interests in protecting them from harm and exploitation.

The typical counterargument is that safeguards can be put in place to ensure that no ineligible patient receives assisted dying. Central to this belief are faith in the clinical judgment of physicians and their expertise in determining medical futility and capacity for decision-making. However, evidence suggests that this may not be the case and that there should be serious concerns about the use of assisted dying for mental disorders. In countries where assisted dying has been legal for many years, such as Belgium and the Netherlands, there has been a concerning trend of permissive incrementalism that some consider has gone too far.<sup>103</sup> Moreover, the general reliance on physician expertise and judgment as the primary safeguard appears insufficient, and may put patients with mental disorders at greater risk. Indeed, there is evidence of a cultural shift in physician attitudes in favour of assisted dying for certain mental disorders, such as dementia, with corresponding increases in its use.

Assisted dying in the context of mental disorders presents numerous clinical, ethical and legal challenges, many of which are novel. The potential effects that mental disorders can have on decision-making abilities, the lack of proximity to end of life, the inherent difficulty in

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<sup>103</sup> *Hamilton, supra* note 50.

determining whether a mental disorder is irremediable, the right to refuse other treatment options, the lack of rigorous and reliable capacity assessments, the difficulty of detecting and holding physicians accountable for inadequate assessment, the varied legal definitions of mental disorders, and the suboptimal state of the Canadian mental health system represent many interrelated problems that require resolution before assisted dying for mental illness could be reliably and ethically implemented. Many of these factors relate to deeper, fundamental problems with care for mental health, which demand attention in their own right. While each is concerning on its own, their cumulative effect raises serious concerns about the use of assisted dying for mental disorders.