



Canadian Psychiatric Association
Association des psychiatres du Canada

Results of Member and Stakeholder Consultation on CPA Discussion Paper

MEDICAL ASSISTANCE IN DYING (MAID) FOR PERSONS WHOSE
SOLE UNDERLYING MEDICAL CONDITION IS A MENTAL
DISORDER: CHALLENGES AND CONSIDERATIONS

The views represented herein do not necessarily reflect the policies and opinions of the Canadian Psychiatric Association.

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Translation: Josée Tremblay

Background

On Feb. 24, 2020, the federal government introduced Bill C-7 with proposed changes to the Criminal Code eligibility criteria for medical assistance in dying (MAiD). The bill was introduced following a Superior Court of Quebec decision that struck down the “reasonably foreseeable” provision in Canada’s assisted dying legislation ([Truchon c. Procureur général du Canada](#)). The House of Commons passed Bill C-7 on Mar. 11, 2021, and on Mar. 17, 2021 it received [Royal assent](#).

People whose sole underlying medical condition is a mental disorder (MD-SUMC) are temporarily excluded from eligibility for MAiD under Bill C-7 until Mar. 17, 2023. The federal government assembled and in August 2021 announced [an expert panel to examine the issue](#) and to recommend safeguards by March 2022.

CPA Discussion Paper and Stakeholder Consultation

In response to Bill C-7, the pending expiry of the prohibition on MAiD in the context of mental disorders alone, and input received from members through its [most recent consultation process](#), the CPA published a [discussion paper](#) in August 2021. The discussion paper was a means to obtain further input from members and from more than 60 stakeholder organizations that were invited to comment (see Appendix).

In addition to providing an overview of eligibility for MAiD in Canada and the role of the psychiatrist, the CPA’s discussion paper focuses on irremediability and eligibility for MAiD, particularly where natural death is not reasonably foreseeable, informed consent and capacity to consent, and potential safeguards for MAiD for MD-SUMC.

Results of Discussion Paper Consultation

While some psychiatrist respondents remain opposed to any access to MAiD for those with MD-SUMC, based on the majority of feedback CPA has received, the points raised in the CPA’s discussion paper reflect the primary areas of concern for psychiatrists.

Among respondents who are opposed to MAiD for MD-SUMC, a small number wanted psychiatrists and CPA to take a stand against MAiD to facilitate hope and recovery, and to protect psychiatrists, patients and families from “the ethical and moral fall-out that MAiD forces on the profession.” Another asked if Canada would be making something legal that, given the history of vulnerable populations under regimes of the past, could be abused under future, unforeseen circumstances. The fact that poverty, inadequate housing, social isolation and other disparities are common among people with mental illnesses and contribute immensely to suffering was noted by three other respondents: “This is the most troublesome and risky aspect of this regime: the likelihood of providing death to people who simply cannot afford or obtain the basics of a dignified life. Physicians cannot allow themselves to become instruments to remove people from a society that refuses to provide an adequate social safety net for highly vulnerable members.”

The remainder of comments and recommendations received from psychiatrists and stakeholder organizations is summarized below based on the major headings of the CPA’s discussion paper, which are:

- Comprehensive clinical assessment of mental disorder,
- Robust eligibility assessment process,
- Durability and voluntariness of the request; and
- Effective and timely oversight process.

Comprehensive clinical assessment of mental disorder

Separate from any MAiD eligibility assessment, it is essential that at least one independent (i.e., not the treating) psychiatrist who has expertise in the mental disorder in question completes a comprehensive clinical assessment to validate whether the patient has received an accurate diagnosis and if they have had

access to evidence-based mental health assessment, treatment and supports for an adequate period of time based on generally accepted standards of care.

Psychiatrists are the only specialists in mental disorders who can make a diagnosis based on a comprehensive assessment that includes a mental and physical examination, laboratory tests, medical imaging and a detailed psychosocial history. [Psychiatrists](#) assess, diagnose, treat and prevent mental disorders, which may include emotional, cognitive or behavioural disturbances that manifest either alone or in combination with other medical or surgical disorders, at all stages of life.

Virtual consultation, where in-person assessments are not practicable, would allow for greater access to assessments from psychiatrists, especially for patients living in remote, northern or underserved areas. This will also enhance access to subspecialties lists if needed. An independent assessment will also avoid potential bias where the treating psychiatrist has agreed to provide an eligibility assessment for MAiD.

Robust eligibility assessment process

It is essential that at least one independent (i.e., not the treating) psychiatrist with expertise in the mental disorder be one of the eligibility assessors of a patient who wants to be considered for MAiD on the basis of MD-SUMC.

In response to the CPA discussion paper, some psychiatrists said they would like to see a mechanism for assessors to discuss a request for MAiD after they each complete their initial eligibility assessments separate of one another. The rationale given for this suggestion is there may be situations where data available to one assessor is not always available to the second (e.g., a long-standing provider versus a new consultant), with the potential for an assessor to alter their opinion if there is other information.

Concern was also cited about the potential for a “cottage industry” may spring up of psychiatrists operating outside the publicly-funded system and doing independent medical examinations for patients seeking MAiD for MD-SUMC and charging hefty fees for such approvals (the respondent said this has occurred in the U.S. already).

CPA’s discussion paper suggested various mechanisms for addressing disagreement between assessors (e.g., seeking a third opinion as a tie-breaker, submitting to a committee of experts for review, a judicial process). Other suggestions put forward during the CPA’s consultation included requiring a common approach across provinces and territories, and a set amount of time to elapse (e.g., one year) before any reassessment could occur following a situation where both assessors say no to an MD-SUMC request. Concerns were noted by one respondent about using tie-breakers as it relates to the assessment of whether to proceed with an intervention that causes death.

CPA also heard a concern for how to ensure access to subspecialists in the event that such a consultation may be necessary. For example, could this be accomplished virtually, or could this be done as a physician-to-physician consult to ensure the psychiatrist assessor is aware of all treatment options for the specific disorder and can provide full informed consent to the patient or be able to suggest resources that have not yet been considered. CPA also heard concerns that the threshold for access to MAiD would be lower in the elderly population due to an ageist, pervasive and stigmatized approach to care for the elderly.

Documentation should demonstrate that standard treatments, including pharmacological, psychotherapeutic and non-pharmacological therapies for the specific mental disorder as well as social/environmental supports, have been offered, attempted and failed over a sufficient period of time and that there are no other accessible reasonable alternatives.

In the context of mental disorders there is no generally agreed upon definition of incurability; within the field of psychiatry, there are some who do not accept that any mental disorder is incurable and will argue that there is always another treatment that can be attempted. The CPA’s most recent consultation in 2021 has underscored this lack of consensus. Given that incurability is one of the eligibility criteria to receive MAiD in Canada, there is the potential that patients may be found eligible by one psychiatrist and not another, based on the latter’s determination that the patient’s mental disorder can be cured or that associated suffering can be relieved. If a

patient refuses recommended treatment for their disorder without good reason, weighing both the potential benefits and burdens, they are unlikely to have met the eligibility criterion for incurable.

Comments received in response to the discussion paper highlighted the high level of concern about the ability to definitively determine that a mental illness is “irremediable,” given the lack of scientific evidence in this area. Other comments reflected the need to assess “irremediability” within the clinical and scientific parameters that exist at the time of the request, versus considering the request in the context of potential interventions that might evolve in the future. Other comments highlighted the importance of considering socioeconomic determinants of health, which play a key role in each person’s experience of illness and suffering and adaptability to mental illness.

With respect to capacity, CPA received comments that physicians are already assessing and providing MAiD for patients with a concomitant mental illness but whose request for MAiD is based on another medical condition. Some respondents queried whether the [Starson](#) criteria were sufficient in the context of an intervention that causes death. Others were concerned about the potential for people requesting MAiD on the basis of MD-SUMC being held to a higher standard based solely on their diagnosis, which some noted may not be sufficient to address the legislative objective of balancing patient autonomy with protecting vulnerable persons. Clear guidance on whether patients with continually changing capacity require ongoing psychiatric assessment to ensure they continue to be eligible for MAiD was also requested. Guidance from professional bodies to help physicians in assessing MAiD requests, as well as formal training for assessors and providers, will be needed to reduce variability in practice. The Canadian MAiD Curriculum Development Committee is developing educational modules, including one for complex capacity assessments, that could help provide this training.

CPA’s discussion paper stated the importance of providing patients found ineligible for MAiD with ongoing care and treatment, and one benefit of MAiD assessments in this circumstance is they may help inform next steps in treatment planning. The complexity of these assessments underscores the need for involvement by psychiatrists who, by virtue of their training, are clinical experts in evaluating the biopsychosocial aspects of mental illness.

Both acute and chronic suicidal ideation must be considered and evaluated to make a best determination as to whether the patient’s wish to end their suffering represents a realistic appraisal of their situation rather than a potentially treatable symptom of their mental illness.

Organizations and individuals who provided feedback on the discussion paper cited concern about the potential for MAiD to be used as a purposeful means to fulfill suicidal ideation, or that its availability for MD-SUMC could be perceived as validating suicide as a solution for suffering. The difficulty of separating out suicidal patients, particularly in patient populations where recurrent suicidality is a feature (e.g., borderline personality disorder), was also mentioned as being of particular importance while assessing capacity.

Some respondents are of the opinion that when someone is not dying as a result of their particular condition, MAiD is suicide and the act of providing it is doctor-assisted suicide. A number emphasized the need to ensure supports are in place for anyone found ineligible for MAiD due to suicidal ideation to keep them from harming themselves.

The assessment process should be trauma-informed and should gather multiple perspectives on the patient’s illness and course of treatment.

A comprehensive eligibility assessment process must allow for ongoing necessary and potentially serial assessment and evaluation with the patient, their current and past psychiatrists/clinicians, multidisciplinary team members, and—with the patient’s prior consent—the patient’s family and/or friends. This may also permit necessary time to re-engage a person back into treatment and care in the circumstance where they do not meet eligibility requirements.

Current and former health care providers should be required to provide collateral information in the form of charts or verbal discussions with MAiD assessors. This includes allowing current MAiD assessors access to all previous MAiD assessments. If a health-care provider refuses to provide collateral history, then the MAiD assessors must rely on all documents that they can procure through willing health-care providers and through portals such as Connecting Ontario. There may be times where, in the absence of collateral, the assessor would

need to refer a patient to expert consultants for additional information about the patient and/or diagnosis. If the patient refuses access to collateral information without good reasons, the MAiD eligibility criteria may not be met.

The assessment should also be trauma-informed, with the assessors recognizing and inquiring about the role of trauma in the patient's view of themselves and their situation, and also recognizing that a trauma history can make medical interactions particularly challenging, and that patients should not be dismissed due to the manner in which they relate to the assessors/providers. Many people with complex mental and/or physical conditions have trauma histories that have never been addressed, which can exacerbate their symptoms.

The template for comprehensive assessments should be standardized to ensure a rigorous approach by assessing psychiatrists, and to mitigate any practitioner bias.

These issues again highlight the CPA's primary stance to ensure that Canadians have equitable access to evidence-based and culturally-safe care.

Durability and voluntariness of the request

Requests should be considered and sustained and not result from a transient or impulsive wish especially in the case where a mental disorder is episodic in nature.

Consideration should be given to the nature of the mental disorder, the length of time since diagnosis, and whether the patient has been considering MAiD for some time. [Some psychiatrists suggest that must be at least a 10-year span of illness](#) (neurodegenerative disorders excluded), or even 10 years since the first assessment by a psychiatrist.

Experiences and perceptions of stigma, vulnerability, and of being a burden to society have the potential to influence a person's decision to request MAiD in both mental and physical illness. A number of submissions CPA received in response to its call for comment on the discussion paper expressed the concern that societal pressures might increase a person's sense that MAiD is the solution that society, particularly caregivers and/or family and friends, might be hoping they will take. One asked whether there was a role for health-care providers other than psychiatrists in helping to establish voluntariness.

The difficulty of navigating whether and when to raise the possibility of MAiD with patients where death is not reasonably foreseeable (i.e., Track 2) was also noted in response to CPA's discussion paper.

It was noted in the CPA's consultation that while the legal benchmark for assessing the durability of the request has been set at 90 days for Track 2, this may not necessarily be the optimal time frame for those with MD-SUMC, and nothing in the law would prevent assessors from recommending a longer period.

Effective and timely oversight process

Alongside an oversight process, it is important to establish a coinciding research agenda for evaluation purposes and to modify policies and practices in relation to safeguards as needed.

Currently the oversight process for MAiD varies among provinces. It has been suggested that, as an added layer of protection for patients with mental disorders as their sole underlying medical condition and for consistency, the oversight process be standardized across provinces. Establishment of a prospective review process at the federal level of MD-SUMC requests for an initial period of time (e.g., two to five years) could allow for concerns or issues to be identified and addressed before a move to retrospective reviews at the provincial level. Those leading the oversight process should have expertise in mental disorders, assessment and provision of MAiD, ethics, and the law. Once a person is found eligible, the prospective review process would need to take place in a timely manner to avoid extending the person's intolerable suffering.

Appendix

Stakeholders Invited to Comment on the Discussion Paper (Alphabetical Order)

Alberta Psychiatric Association*
Assembly of First Nations
Association des médecins psychiatres du Québec*
Association québécoise pour la réadaptation psychosociale
British Columbia Psychiatric Association*
Canadian Academy of Child and Adolescent Psychiatry*
Canadian Academy of Consultation-Liaison Psychiatry*
Canadian Academy of Geriatric Psychiatry
Canadian Academy of Psychiatry and the Law
Canadian Association of MAiD Assessors and Providers
Canadian Association of Social Workers
Canadian Association of Suicide Prevention*
Canadian Centre on Substance Use and Addiction
Canadian Counselling and Psychotherapy Association*
Canadian Federation of Mental Health Nurses
Canadian Indigenous Nurses Association
Canadian Medical Association
Canadian Medical Protective Association*
Canadian Mental Health Association
Canadian Nurses Association
Canadian Pharmacists Association
Canadian Psychological Association*
Collège des médecins du Québec
College of Family Physicians of Canada*
College of Physicians and Surgeons of Alberta
College of Physicians and Surgeons of British Columbia
College of Physicians and Surgeons of Manitoba
College of Physicians and Surgeons of New Brunswick
College of Physicians and Surgeons of Newfoundland and Labrador

College of Physicians and Surgeons of Nova Scotia
College of Physicians and Surgeons of Ontario*
College of Physicians and Surgeons of Prince Edward Island
Congress of Aboriginal Peoples
Dying With Dignity Canada
Federation of Medical Regulatory Authorities of Canada*
Inclusion Canada
Indigenous Physicians Association of Canada
Joint Centre for Bioethics
Manitoba Psychiatric Association
Medical Psychotherapy Association of Canada
Mental Health Commission of Canada
Mood Disorders Association of Canada*
National Initiative for Eating Disorders
New Brunswick Psychiatric Association
Newfoundland and Labrador Psychiatric Association
Nova Scotia Psychiatric Association
Ontario Psychiatric Association*
Professional Licensing, Government of the Northwest Territories*
Professional Services, Government of Nunavut
Relief (formerly Révivre)
Réseau Avant de Craquer (formerly FFAPAMM)*
Royal College of Physicians and Surgeons of Canada*
Saskatchewan Psychiatric Association
Schizophrenia Society of Canada*
Waypoint Centre for Mental Health Care*
Yukon Medical Council*

Comments from individuals (CPA members and non-member psychiatrists): 18

Unsolicited submissions (from organizations or groups of individuals): 6

*response received

Canadian Psychiatric Association
701 – 141 Laurier Avenue West, Ottawa ON K1P 5J3
www.cpa-apc.org