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Dedicated to quality care

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Preliminary Remarks on Physician-Assisted Death

**Presented to the
External Panel on Options for a Legislative
Response to *Carter v. Canada***

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Dear Members of the External Panel,

The Canadian Psychiatric Association (CPA) thanks you for the opportunity to discuss issues relevant to the Physician Assisted Death (PAD) issue in response to the Supreme Court of Canada *Carter v. Canada* decision. The CPA is the national voice for Canada's 4,700 psychiatrists and more than 900 psychiatric residents. Founded in 1951, the association is dedicated to promoting an environment that fosters excellence in the provision of clinical care, education and research.

For each of the four issues the panel has requested feedback on, we are providing Points for Consideration and, if applicable, Recommendations. The focus of our submission is on issues specifically relevant to mental illness and the role of psychiatrists.

Issue 1: Different forms of physician-assisted dying: (1) assisted suicide, where a doctor prescribes a lethal dose of medication that patients take themselves, and (2) voluntary euthanasia, where a doctor injects a lethal dose of medication to terminate a patient's life on the patient's consent

Points for Consideration

In terms of either of the above issues related to prescribing or administering a lethal dose of medication to terminate a patient's life, this falls outside the scope of clinical practice and expertise of psychiatry.

Recommendation

1. The CPA does not anticipate or recommend that psychiatrists be involved in the actual procedure of prescribing or administering lethal doses of medication.

Issue 2: Eligibility criteria and definition of key terms

Points for Consideration

In its ruling in *Carter v. Canada*, the Supreme Court discusses physician-assisted death in the context of "a competent adult person who clearly consents to the termination of life" and "has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." Clarity of key terms and criteria is essential to ensure unwanted risks are mitigated (issue 3) and appropriate safeguards in place (issue 4).

We should first acknowledge it is appropriate to continue using the term Physician Assisted Death (PAD) rather than the term Physician Assisted Suicide, as has sometimes been used in the past. "Suicide" has connotations and clinical relevance in the context of symptoms of mental illness which should not be conflated with the issue of Physician Assisted Death.

When discussing issues of mental illness in the context of PAD, there are two main scenarios that must be considered. The first scenario is whether patients with other medical illnesses for which they are seeking PAD concurrently have a mental illness; the second scenario could be patients seeking PAD on the basis of their mental illness. We will address both these situations below.

Patients seeking PAD for other medical illnesses who concurrently have a mental illness

In the scenario where a person has intolerable and enduring suffering from an irremediable medical illness and concurrently has a psychiatric illness, the primary role of a psychiatrist would be to

assess whether the patient's mental illness is impairing their capacity to make an informed decision regarding PAD. The psychiatrist's role would not be to assess whether the person's medical illness fulfills the required definitions of irremediable, intolerable or enduring, as that determination would need to be made by medical professionals with expertise in the relevant medical illness.

Recommendations

2. In situations where patients have a mental illness, including if they are seeking PAD for other medical illness(es), psychiatrists should be involved in assessing whether the patient's mental illness is impairing their capacity to make a decision regarding PAD.
3. Psychiatrists may be consulted for an opinion but do not need to routinely be involved in all capacity assessments if there is no evidence of a mental illness.

The issue of capacity is discussed further below.

Patients seeking PAD for mental illness

In the event a person seeks PAD on the basis of a mental illness, the terms "irremediable", "intolerable and enduring suffering" and "capacity" need to be considered carefully in the context of mental illness.

Irremediable

If "irremediable" is considered to mean incurable, this could apply to many diagnoses in psychiatry and medicine. Schizophrenia is typically considered a chronic illness and not curable, major mood disorders such as clinical depression or bipolar disorder can be chronic or recurring; likewise in medicine chronic illnesses such as diabetes or arthritis are not curable.

If "irremediable" is considered untreatable, then very few situations in psychiatry would be considered irremediable. Multiple treatment options typically exist for even the most severe instances of mental illness where symptoms and suffering may be treated and reduced, but not cured. There may be times when a patient does not wish to have certain treatments, this is discussed further under capacity below. Also, as discussed further below, the course of mental illnesses is determined not only by biomedical treatments, but also by psychosocial interventions aimed at reducing suffering. Rarely if ever should it be considered 'irremediable' regarding interventions aimed at addressing psychosocial stressors for a person with mental illness.

If "irremediable" is considered terminal, then once again mental illnesses themselves are typically not terminal, although in some severe mental illnesses patients can be at high risk of behaviour that leads to death. The distinction is important since mental illness on its own does not typically lead to a person's death, but the impact of cognitive distortions and impairments in insight and judgement caused by symptoms of mental illness may lead to behaviour that results in death. For example, suicide in cases of clinical depression or other mental illness, or starvation in the context of a severe eating disorder, are behaviours influenced by the patient's mental illness that may result in the patient's death. This risk of death from these behaviours is reduced or eliminated if the symptoms of the underlying mental illness are effectively treated.

Finally, a key point needs to be made regarding the term "Treatment Resistant Depression" (TRD). In media reporting on the PAD issue, TRD has sometimes erroneously been assumed to refer to conditions that are irremediable or untreatable. In reality TRD simply refers to situations where a person's clinical depression has not responded effectively to two different antidepressant trials. TRD does not mean the patient's depression is untreatable, in fact the concept of TRD is used clinically to help guide next steps in management, not to imply there are no more options. Lack of clarity about this could lead to significant confusion about clinical depression and issues of PAD.

Recommendations

4. In the context of mental illness, irremediable should not be considered to mean incurable as this would set the threshold for identifying a condition as irremediable too low (i.e. all chronic mental illness could then be considered irremediable).
5. The concept of irremediable should not be considered as simply identifying the diagnostic condition, but must be considered in the entire context of the expected illness course including considering the potential impact of possible treatment options on suffering and symptoms.
6. Treatment Resistant Depression should not be confused with the term irremediable, and this should be explicitly articulated in any PAD framework.

Intolerable and Enduring Suffering

The subjective assessment of “intolerable” and predictive assessment of “enduring” can both be affected by mental illness.

Mental illnesses can affect cognition and impair insight and judgement. Symptoms of cognitive distortions common with clinical depression include negative expectations of the future, loss of hope and loss of expectation for improvement (even when there may be hope for positive improvement), loss of cognitive flexibility, loss of future oriented thought, and selective ruminations focused on the negative and minimizing or ignoring the positive. There are commonly distortions of a person’s own sense of identity and role in the world, including feelings of excessive guilt and worthlessness, or feeling a burden to others or the world. Additionally, when clinically depressed, people have lower emotional resilience and are less capable of dealing with life stressors.

In mental illnesses with psychotic symptoms, which include schizophrenia but also other illnesses such as in severe clinical depression or bipolar disorder, reality testing is impaired and the person may suffer from frankly delusional beliefs. In anxiety disorders, there is a tendency to focus on negative expected outcomes.

Finally, in understanding and assessing the impact of suffering in the context of mental illness, psychosocial, cultural and environmental factors play a significant role. Helping relieve suffering in these situations cannot rely solely upon biomedical treatments but must include addressing these psychosocial factors. For example, stressors including unstable housing, financial instability, isolation, and others increase suffering of patients with clinical depression, it would be inappropriate if the societal response in such situations was to facilitate these people dying by deeming that person’s suffering enduring and intolerable.

All these issues lead to challenges in identifying when the definitions of “intolerable” and “enduring” are met in the context of mental illness. With active symptoms as above, the symptoms themselves impact the person’s evaluative processes in ways that increase the likelihood they believe their suffering is intolerable and/or enduring. If not for the cognitive distortions described above, that same person, faced with the exact same situation and degree of suffering, is less likely to feel their situation is intolerable and/or enduring.

Capacity

For health care decisions in medicine, the term “capacity” is typically used instead of the term “competent”. When a person has capacity to make a decision, they are deemed capable of making that decision. Capacity involves four broad components:

- The ability to make a choice.
- The ability to understand relevant information.
- The ability to appreciate the situation and the consequences of decisions.
- The ability to manipulate information rationally.

Even when patients with mental illness can express a choice and understand and recall information, their appreciation of the situation (present and future expectations) and ability to manipulate information rationally can be affected by the cognitive distortions cited above. It is this recursive nature of symptoms on the evaluative process, where the very symptoms of mental illness interfere with the person's evaluation of their mental illness and its impact, that poses challenges.

It is also important to recognize that capacity is not universal, it is specific to each decision being made. A person may have capacity to decide to take or not take a medication, for example, but lack capacity to make a rational decision about housing or finances. Similarly, a person may have capacity to accept or refuse a particular treatment, but lack capacity to make a rational decision about dying. Combined with the cognitive distortions described above, this may raise situations where a person is capable of refusing suggested treatments, because for example they are legitimately concerned about potential side-effects, but would not be deemed capable of deciding to pursue PAD.

Medical decision-making often weighs the balance of autonomy, or the person's right to make a decision, and beneficence, or the medical team's belief of what is best for the patient. If autonomy is considered to be the person's right to make an independent decision without external control or influence, with mental illnesses the cognitive symptoms of the illness itself may challenge the patient's autonomy; the symptoms may lead to decision-making and behaviour that the patient would not follow if they were not subject to cognitive distortions of the illness.

These issues are particularly important to highlight given the serious and irreversible nature of the PAD decision. Thus with mental illnesses and PAD decisions, the principle of beneficence may need to play a more prominent role in the decision-making process. This is not to challenge the patient's autonomy, rather it is necessary since the patient's autonomy may be undermined by symptoms of the mental illness itself. Further, even when it may appear that a person with mental illness is capable of making a PAD decision, it may be exceedingly difficult if not impossible to rule out if their decision to pursue PAD is influenced by illness-based cognitive distortions.

It is also worth pointing out that in its ruling the Supreme Court cited the trial judge's ruling in Ms. Taylor's case that "Ms. Taylor's right to life was engaged insofar as the prohibition (on PAD) might force her to take her life earlier than she otherwise would if she had access to PAD" ("the prohibition on PAD had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable"). While this may be true of progressive or degenerative medical conditions that lead to increasing physical incapacity, this is rarely if ever the case with mental illnesses.

Recommendation

7. When mental illness is present, especially if the PAD decision is being based on intolerable and enduring suffering from a mental illness, if there is lack of clarity about the degree of impact of cognitive distortions on the patient's decision-making process, a patient may not be able to be deemed capable for making a PAD decision. In such cases, the principle of beneficence may need to play a greater role.

Issue 3: Risks to individuals and society with PAD

Points for Consideration

In the context of mental illness many of the risks have been discussed above. Specifically, mental illness symptoms pose a risk to a patient's capacity to make a PAD decision by virtue of the symptom's impact on the patient's decision-making process.

The impact of mental illness on cognitive processes also poses a potential risk to the certainty of clinical capacity assessments. This is not to suggest that someone with mental illness cannot be capable to make a PAD decision, rather it raises the question of whether clinically we are able to properly assess their capacity (i.e., do we know whether, absent the effects of the mental illness on their cognitive patterns, insight and judgement, they would still want to die?).

Additionally, those with serious mental illness are already amongst the most vulnerable group in society. Particularly vulnerable populations include those with intellectual and developmental disabilities, the elderly with dementia, and children and adolescents with various psychiatric conditions. Caregiver burden levels can be high in many of these situations, and there may be financial implications related to the patient's caregiving needs or estate inheritance, all of which can influence decision-making. In situations where they lack the capacity to make decisions for themselves, it is essential that any PAD framework contain robust safeguards and oversight of any substitute decision-making process to ensure appropriate decisions are made in the best interest of the patient.

The safeguards outlined below would help mitigate these risks.

Issue 4: Safeguards to address risks and procedures for assessing requests for assistance in dying, and the protection of physicians' freedom of conscience

Points for Consideration

In cases where mental illness is present, given the impact of illness symptoms on the decision-making process and the serious and irreversible nature of the PAD process, it is essential there be multiple safeguards over a period of time.

Spreading the evaluative process into different components, each done by those expert in that particular domain, would serve as one safeguard. Determining whether an illness is irremediable and the patient likely to suffer from intolerable and enduring suffering is an assessment of the impact and projected course of the patient's illness; determining their capacity to make a PAD decision is a related but separate issue. Rather than conflating these issues in one assessment, these assessments could be carried out by different experts.

Spreading the evaluative process over time provides another safeguard, as it reduces the risk the patient makes a PAD decision purely in the context of a transient period of increased suffering or weakness. For mental illnesses, where the symptoms of illness may impact cognition, insight and judgement, this is particularly important. In this regard, when mental illness is present, it is important any PAD framework account for timeframes often required prior to response to treatment is seen. In cases of clinical depression, four to six weeks often need to pass before success or failure of treatment can be assessed.

As discussed above, capacity is specific to each decision, and a person may have capacity to accept or refuse a treatment but lack capacity to make a PAD decision. In such cases it is possible that a patient continues to suffer from higher levels of symptoms and distress than they otherwise might if they had certain treatments, and that this results in ongoing cognitive distortions and impairment of insight and judgement in the context of PAD decisions. For example,

electroconvulsive therapy (ECT) remains a highly effective treatment for many cases of clinical depression. However, there may also be side-effects of memory loss during the time of treatment, or other reasons patients may not wish to have this treatment. Similarly, other treatments that remain in the research stage, or may be considered invasive in that they involve surgery, have been shown to offer potential promise to some patients with very severe symptoms. The Supreme Court indicated that "irremediable....does not require the patient to undertake treatments that are not acceptable to the individual." This raises the challenging question of what treatments a patient with mental illness would need to have prior to concluding their mental illness is irremediable and leading to intolerable and enduring suffering, especially if the symptoms of their mental illness are impacting their cognition, insight and judgement, and/or decision-making process regarding acceptability of other treatments.

Finally, provincial mental health legislation includes mechanisms for review boards or similar to adjudicate on cases where patient capacity is at issue. Similarly PAD panels could be operationalized so the final decision does not rest with individuals directly involved in administering clinical care to the patient.

Recommendations

8. PAD decisions should not be based on a single assessment, but rather on multiple assessments by different experts. The appropriate expert for each piece of the PAD decision (i.e., illness impact and course versus patient capacity to decide on PAD) should be used. These expert opinions could inform a PAD panel.
9. In cases where mental illness is present and PAD being sought, especially if the mental illness is forming the basis of the PAD request, a minimum of six weeks needs to elapse between sequential assessments, and reasonable treatment options should be pursued during this time.
10. The CPA supports psychiatrists 'opting out' of the PAD process on grounds of freedom of conscience. In such circumstances, the patient should have access to another psychiatrist being involved in the PAD process if required.

Thank you again for seeking the input of the CPA on this important issue, we look forward to further discussions with you.

Respectfully submitted,

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