MAiD for Mental Illness Patients - What's Holding Us Back?

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Nhat Hung (Benjamin) Lam[1]

[1]University of Ottawa, Ottawa, Ontario, Canada

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On March 17, 2021, Bill C-7 amending the legislation for Medical Assistance in Dying (MAiD) received royal assent, expanding MAiD access to numerous Canadians suffering from incurable illnesses.[1] Among the major changes is the added eligibility for people suffering from a "grievous and irremediable medical condition" even if death is not imminent or reasonably foreseeable. However, individuals whose sole medical condition is a mental illness remain ineligible for another two years, while the government gathers expert opinions to construct necessary safeguards and qualifying criteria.[2] This essay will explore the controversies surrounding MAiD access for mental illness patients and propose the necessary measures to ensure safe and equitable implementation for this population.

One prominent opposing viewpoint surrounds the "grievous and irremediable" definition of mental illnesses.[3] First, grievousness refers to the subjective suffering of patients, which they deem intolerable and not amenable to alleviation by methods acceptable to them.[1] The grievousness of mental illnesses is widely recognized by clinicians, the public, and legislators alike. It manifests itself in the psychological anguish that can and does result in physical suffering and co-morbidities.[4,5] It is undeniable that such suffering warrants relief, whether from evidence-based treatments or consideration for a medically assisted death. Nevertheless, when it comes to psychiatric conditions, this is accompanied by the complex temporality of symptoms and morbidity of these illnesses. Save for neurodegenerative diseases and refractory eating disorders, both of which

qualify as eligible conditions under MAiD, the severity of many psychiatric conditions waxes and wanes: their long-term trajectories remain unpredictable even with the best existing evidence.[6] In this view, a severe mental illness does not translate to an irreversible downward spiral of anguish and declining function, but rather a chronic condition with episodic exacerbations which, with proper treatments, could remain manageable and tolerable to patients for extended periods of time.[7] It is worth noting, however, that mental illness suffering rarely exists in a vacuum: it permeates throughout all aspects of a person's life, and the neurologic and physical toll it takes on them is often cumulative and contributes significantly to their long-term decline.

Such interpretation brings us to the discussion of whether mental illnesses are "irremediable". While grievousness is a subjective experience of one's illness, irremediability should be guided by objective medical evidence. Currently, there is no established threshold for when a mental illness should be considered irremediable.[2,6] One aspect of this complex question arises from the aforementioned unpredictability of psychiatric episodes: their onset, severity, and duration. Given such symptom temporality, a question arises of whether allowing psychiatric patients to seek MAiD is ethical if there is an appreciable chance that they will recover from an episode. Given this possibility, when can one's mental illness be deemed irremediable? It is conceivable for patient's physical state to deteriorate with each psychiatric episode to the point where a natural death becomes reasonably foreseeable and qualifies them for MaiD. Yet a far more prevalent and ethically murky scenario is where a person may decide that despite the possibility of subsequent recovery, the mere prospect of an exacerbation would be intolerable and unacceptable to them, and thus, might wish to access MaiD.[4] To follow their request would require fundamental changes in the way the law defines "irremediability", opening the gate for many other chronic conditions.[8] Without stringent safeguards surrounding this qualifier, its ambiguity could result in vastly different care decisions – one patient might have their request for MAiD approved and their life ended, whereas another might be persuaded to prevail their current episode.[7] While variations in clinical judgment are commonplace in medicine, they are not acceptable when a patient's life is at stake. Therefore, physicians providing psychiatric care have the responsibility to connect with their patients to understand their views of their illnesses and how, if MAiD ever comes under consideration, they would like to approach it.

Lastly, mental health patients' right to access MAiD was opposed on the basis that a significant portion of their suffering was due to social determinants of health.[9] Mental disorders remain a leading cause of disability in Canada.[10] Despite efforts to raise awareness and support, individuals with mental illness still struggle to obtain and maintain employment.[11] Stable employment is central to one's ability to cope with their illness by forming the foundation for other determinants such as economic participation, social inclusion and housing security.[12] These social connections not only offer patients financial stability and emotional support, but also provide them with a sense of self-worth and hope, the loss of which underpins the psychological suffering in mental illness patients and undoubtedly drives them to seek MAiD.[13] Lack of access to mental health care is another tremendous challenge.[4] Wait times are long and ever-increasing for mental health services (averaging at more than 1.5 years), as well as for emergency and specialist care.[14,15] Additionally, structured psychotherapy, alongside pharmacotherapy, albeit shown to be highly effective, are not universally publicly covered,[16] imposing yet another socioeconomic barrier to treating mental illnesses. Therefore, employment and access to high-quality care are key areas with immense potential for advocacy and advancement. It is one thing for a person to seek relief in death after having exhausted all the acceptable support and treatments available to them. But it would be unconscionable for us to let them end their lives to escape the socioeconomic deprivation and lack of resources that precipitate their deterioration in the first place.

In conclusion, bodily integrity and the right to a dignified death without undue suffering is fundamental to the patient autonomy with any serious medical conditions. It remains steadfastly true that Canadians whose mental disorders have progressed beyond their ability to cope and manage should and must have the right to relieve their suffer via MAiD. Notwithstanding, it is also our responsibility as a society, as fellow Canadians and as healthcare professionals to advocate for changes, not only in legislations surrounding MAiD but also structural and social support to ensure that people will only access MAiD when they absolutely have to.

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