



Euthanasia requests in a Canadian psychiatric outpatient clinic: A case series part 2 of the McGill University euthanasia in psychiatry case series



Antoine Perreault^{a,*}, David Benrimoh^a, Allan Fielding^b

^a McGill University, Department of Psychiatry, 1033 avenue des Pins Ouest, Montreal, QC H3A 1A1, Canada

^b Allan Memorial Institute, 1025 avenue des Pins Ouest, Montreal, QC H3A1A1, Canada

ABSTRACT

The Canadian province of Quebec enacted in 2014 a legislation that permitted medical assistance in dying (MAID) under specific conditions and the rest of Canada followed suit in June 2016. In this article, which is the second in a set of case series of requests for MAID in Canadian psychiatry, we present the cases of two patients who made a request for MAID to their treating psychiatrist in an outpatient clinic. While one is advanced in age and suffering from intense physical and psychic pain with little if any psychiatric comorbidity, the other is a young and medically healthy woman who nonetheless suffers from extensive psychiatric comorbidity. This article discusses both cases in light of recent scientific literature and case law that is slowly emerging in Canada, focusing on the concepts of the end of life and its legal definition as well as psychic suffering and its management in those wishing to receive physician-assisted dying. In our conclusion, we stress the need to clarify the definition of treatment resistance, the necessity to determine each physician's role when many are involved, as well as the importance of treating psychic pain holistically, which can sometimes require going beyond standard psychiatric care.

1. Introduction

In 2014, the Canadian province of Quebec enacted a legislation that permitted medical assistance in dying (MAID) under specific circumstances; the rest of Canada followed suit in June 2016 after a historic ruling by the Supreme Court of Canada, with the final effect of partially decriminalizing MAID throughout the federation (Canada, 2016; Quebec, 2014; Supreme Court of Canada, 2015). This new state of affairs has brought questions about MAID in the context of mental health and the practice of psychiatry—with two major interrogations being whether or not MAID will be made accessible to those suffering only or primarily from mental illness and who are not clearly near the end of life, and what the new clinical reality will be if this happens. This article is the second in a set of case series of requests for MAID by psychiatric patients and seeks to continue exploring these questions. In the first paper (Benrimoh, Perreault, & Van Den Eynde, 2017), we noted that, while individuals solely suffering from psychiatric disorders are not excluded *de jure*, MAID is not available *de facto* to most of them because of the end-of-life criteria included in both Quebec provincial law (Quebec, 2014) and Canada federal law (Canada, 2016). This remains the reality as of the writing of the present article and will be important to keep in mind throughout its reading. The objective of this second paper is to present the cases of two patients who were seen in an outpatient setting and who requested MAID on the basis of significant psychic (and in the case of one patient, also physical) suffering. The

context differs from the patients in the first case series, who all presented to the psychiatric emergency department. Both patients in the current article were not initially granted MAID as they did not meet inclusion criteria as stated by the law at the time of their original demand, though one of the two eventually received MAID given her age, significant physical comorbidities and the suffering these caused. There is currently an ongoing debate as to whether to allow MAID for patients that are not at the end of life (Downie & Dembo, 2016; Kirby, 2017; Yarascavitch, 2017). In this context, given the possibility that Quebec and Canada's legal framework may change over the next few years to reduce the importance of imminent death as a criterion for MAID eligibility, these two cases may be instructive as examples of patients whose requests for MAID due to psychic suffering may become eligible without death being imminent (at least initially) in the near future (Benrimoh et al., 2017). Instead of comparing these cases with international data as was done in our previous article, we will discuss them in light of recent scientific literature and case law that is slowly emerging in Quebec and the rest of Canada. The overall objective of this exercise is to encourage reflection on the part of mental health professionals as to how they should be involved in the ongoing debate around MAID for persons afflicted by psychiatric disorders, as well as what factors should be taken into account when evaluating the extension of MAID to patients suffering only from mental illness. It is important to note, however, that it is not our goal to take a moral or political stand on this issue; our sole objective is to prompt reflection

* Corresponding author at: McGill University, Department of Psychiatry, Canada.
E-mail address: antoine.perreault@mail.mcgill.ca (A. Perreault).

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and discussion, such that ensuing decisions will be made in a deliberate and thoughtful manner. We will begin by briefly describing Quebec's current legal framework since both patients in this case series were seen in this Canadian province. The case studies will then be presented with a discussion following.

1.1. Historical and local context

The evolution of Quebec's legal framework has been previously described in detail (Benrimoh et al., 2017), but we will summarize key points here. In 1992, the Superior Court of Quebec confirmed in two different cases that voluntary passive euthanasia (i.e., the withdrawal or withholding of life-sustaining treatments at a competent patient's request) does not fall under criminal prohibition in Canada (Superior Court of Quebec, 1992a; Superior Court of Quebec, 1992b). The following year, the Supreme Court of Canada assessed the constitutionality of the criminal prohibition of voluntary active euthanasia (i.e., the act of ending a patient's life at their request) and finally ruled that voluntary active euthanasia would remain a criminal act under Canadian law (Supreme Court of Canada, 1993). As such, passive euthanasia was allowed but active euthanasia remained forbidden throughout the federation. Quebec and Canada's legal frameworks remained unchanged until December 2015 when Quebec's new Act Respecting End-of-Life Care came into force, making the province the first of Canada's jurisdictions where there was a legislation permitting MAID under specific circumstances (Benrimoh et al., 2017; Quebec, 2014). During that same period, the Supreme Court of Canada reassessed the constitutionality of the blanket ban on active euthanasia and unanimously ruled that it was unconstitutional and should be partially decriminalized as it violated the right to life, liberty and security of the person enshrined in Section 7 of the Canadian Charter of Rights and Freedoms, forcing the federal government to enact a law to regulate the practice (Canada, 1982). Finally, in June 2016, Canada passed the Medical Assistance in Dying Act which since governs the practice all across Canada (Canada, 2016a). At the present time, two legal documents regulate MAID in Quebec: the provincial End-of-Life Care Act and the federal Medical Assistance in Dying Act (Canada, 2016a; Quebec, 2014). Additionally, the Supreme Court of Canada's *Carter* decision remains an important document that can play a central role in the interpretation of the constitutionality of the first two (Supreme Court of Canada, 2015). All of these documents include eligibility criteria that, while being similar in many ways, can diverge significantly in their wording. They all require patients to be competent, to suffer from a serious and irremediable condition and to experience irreversible and unbearable suffering in order to be eligible for MAID. However, only the federal and Quebec laws explicitly demand patients to be at the end of life and to be in an advanced state of irreversible decline (see Table 1 for exact wording of the criteria in each document). So far, the three aforementioned legal instruments have not been compared against each other in court and there is ongoing debate regarding the constitutionality of the both federal and provincial end-of-life requirements (Lemmens, Kim, & Kurz, 2018; McMorrow, 2018). The Canadian legal framework is therefore not crystallized yet and major changes may occur. In fact, there are ongoing cases that are attempting to challenge the constitutionality of the Quebec and federal laws before the courts (Canada, 1982; Quebec Court of Appeal, 2018). Additionally, the federal government itself is reflecting on the idea of broadening the eligibility for MAID to mental health patients (The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, 2018). For now, two main guidance bodies have made preliminary recommendations to Quebec physicians. The Collège des Médecins du Québec has suggested prioritizing Quebec law over the federal legislation and the *Carter* decision (Collège des médecins du Québec, 2016a; Collège des médecins du Québec, 2016b). The Canadian Medical Protective Association has recommended complying with both the Quebec and Federal laws, always "adhering to

whichever requirements are more restrictive," which usually tends to be the Quebec law (Canadian Medical Protective Association, 2016). We will therefore assume in this article when discussing our two cases that Quebec's End-of-Life Care Act prevails. There are two questions that should be considered when reading the following cases: 1- How should requests for MAID by patients in mental health setting be dealt with at present time? And 2- In light of cases such as the ones we will present, how might Quebec and Canada's legal framework evolve?

1.2. Setting and case selection

The cases in this article were selected from a general adult outpatient psychiatry setting at a tertiary care hospital. The institution from which cases were drawn is located in Montreal and serves a multilingual, socio-economically and ethno-culturally diverse clientele. The case selection was done from the practice of one of the authors (AF) with, as sole inclusion criteria, a recent and spontaneous request for MAID. There were no exclusion criteria.

1.3. Authors disclosure

The authors have no financial conflicts of interest to disclose, but as we did in the first article of this series (Benrimoh et al., 2017), we feel it is important to disclose our personal views on the matter of MAID for psychiatric reasons in order to help readers interpret our work on this often-polarizing question. As such, we disclose the following:

AP was unsure of his position regarding MAID for psychiatric reasons at the time of writing the first case series. While he still feels that the type of illness a patient suffers from (e.g. psychiatric vs others) should not be grounds for granting different rights and opportunities to patients, he is increasingly worried that the challenges inherent in the assessment of the eligibility for MAID of patients suffering from a psychiatric disorder might prevent any objective assessment in clinical settings.

DB is opposed to MAID for purely psychiatric reasons, finding that it provides an end to all possible recovery processes in a class of conditions known for their evolution over time and their sensitivity to socioeconomic factors (such as loneliness). These factors may drive MAID requests and DB believes they should be addressed prior to consideration of MAID as an option in this population. Also, DB believes that the criteria for consenting to MAID for psychiatric reasons are not sufficiently clear and given fact that this class of conditions has sometimes subtle effects on the cognitive processes and perceptions of those who suffer from them, it may be exceedingly difficult to provide clear guidelines.

AF is opposed to providing MAID for purely psychiatric reasons on the basis that the conditions frequently fluctuate and the sense of hopelessness and suffering that drives a request for MAID is strongly influenced by the state of a person's illness at any given time. Much like it is argued that adequate pain control and palliative care options should be a priority for medically ill patients seeking MAID, adequate and even specialized care should be a priority for the severely mentally ill.

2. Cases

The two patients presented below provided consent to the publication of their cases in this article, one of them expressing explicitly that she hoped this would open up the debate and help others who are facing similar challenges.

2.1. Case 1

Ms. D is a 35-year-old single woman who lives on her own and works part-time as a nursing assistant with the elderly while pursuing a degree in graphic arts. She first consulted in psychiatry about 15 years

Table 1
The Quebec, Canada and supreme court's sets of criteria for MAID.

Quebec's Act respecting end-of-life care [1, art. 26]	<p>Only a patient who meets all of the following criteria may obtain medical aid in dying:</p> <ul style="list-style-type: none"> (1) be an insured person within the meaning of the Health Insurance Act; (2) be of full age and capable of giving consent to care; (3) be at the end of life; (4) suffer from a serious and incurable illness; (5) be in an advanced state of irreversible decline in capability; and (6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.
Canada's Medical Assistance in Dying Act [2, s. 241.2]	<p>(1) A person may receive medical assistance in dying only if they meet all of the following criteria:</p> <ul style="list-style-type: none"> (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada; (b) they are at least 18 years of age and capable of making decisions with respect to their health; (c) they have a grievous and irremediable medical condition; (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care. <p>(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:</p> <ul style="list-style-type: none"> (a) they have a serious and incurable illness, disease or disability; (b) they are in an advanced state of irreversible decline in capability; (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.
SCC's Carter decision [3, paragraph 127]	<p>The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case [Ms. Taylor]. We make no pronouncement on other situations where physician-assisted dying may be sought.</p>

ago for symptoms of major depression and posttraumatic stress disorder. Her trauma history was extensive. She was born and raised within a cult. She experienced sexual abuse at the hands of multiple adults with the consent of her parents who saw this as an integral part of their belief system. Her younger brother was similarly traumatized, but together they managed to escape the cult in their late teens and have remained close, sometimes living together, and then apart when their conditions worsened.

Early in her treatment she was hospitalized on multiple occasions for treatment-resistant depression and suicide risk. On the ward, her management was complicated by her openly expecting to use sexual favours as a way to thank people or to curry favour since this was how she had to operate for most of her life. She developed severe heroin addiction, severe anorexia, and significant elements of body dysmorphic disorder. Eventually after multiple treatment programs including Addictions, Eating Disorders, Day Hospital, and an extended course of EMDR therapy her condition stabilized, and she was no longer a frequent visitor at the emergency room.

While EMDR and later courses of cognitive therapy were helpful in reducing some of the symptoms of depression and PTSD, neither therapy nor multiple trials of pharmacotherapy nor treatments such as ECT and rTMS were ever successful in achieving a significant degree of remission in her chronic depression. She found a passion in graphic arts and continued to work her way toward a master's degree, which took time given her inability to take more than a few courses at a time. She also had to miss entire semesters due to intense symptoms that were preventing her to leave her house for weeks at a time. In addition to her core difficulties, she developed significant premenstrual dysphoric disorder (hereinafter PMDD) and severe endometriosis to the point where she was crippled with pain, often one week out of four. With considerable difficulty she finally found a surgeon who would operate and had a hysterectomy with unilateral oophorectomy which has considerably improved her pain and PMDD.

She remains quite disabled by a significant number of ongoing symptoms: frequent relapses into profound depression with suicidal ideation, severe sleep disturbance, bouts of nightmares (partly relieved

by prazosin) and chronic background anxiety and panic attacks. She has had multiple episodes through work where she was the object of unwanted sexual advances which would typically cause a significant setback marked by social isolation and dropping out of treatment for a few months, then finally resurfacing and re-engaging in her follow-up.

Her request for MAID started with simple questions about the new law that had been proposed in Quebec and how it would function (the authors note that this is true of many patients we have seen). Finally, when the law actually passed, she made a more direct enquiry as to how she could apply. As we explored the issue, she spoke of how in spite of all her efforts, the core trauma in her life was never far below the surface, and that it required a great amount of energy to get through her day, afraid that she would be triggered by some random event and plunged back into a cycle of nightmares, panic and fear that would take weeks to subside. She felt that she had received the best care possible but that it was still not enough to afford her any significant quality of life, and that she was far too damaged to ever expect either a normal intimate relationship or even normal work relationships. She had concerns that should she make a suicide attempt and fail, she might wake up with some additional physical burden resulting from her attempt, adding to her overall level of pain and suffering. She reviewed with her psychiatrist how in Quebec MAID is reserved essentially for people dying from a physical illness, with death expected in the near future, making her ineligible. She has been following the legal evolution of MAID in other countries where psychological suffering within mental illness has become acceptable criteria and is watching closely the evolution of the discussion at the Federal level to see if such changes might be coming in the near future. In the meantime, she continues to pursue her studies and seek treatment for her symptom flare-ups.

2.2. Case 2

Ms. E is a delightful 85-year-old woman who unfortunately suffers from both advanced chronic obstructive pulmonary disease (hereinafter COPD) and a severe case of Sjogren's syndrome. She first consulted in psychiatry about two years prior to the writing of this article, referred

by her internal medicine specialist for evaluation of possible major depressive disorder. Her history was negative for any formally diagnosed mental illness and in fact revealed a woman of considerable resilience. She grew up in a wealthy family, living in Asia at the time, and was used to having servants, cooks and nannies around the house. She moved to Canada and married a businessman, and together they raised two daughters and a son who are now married and have families of their own and are scattered across the United States. Through the years she had to undergo the various reversals common to family businesses, and also had to deal with the worsening consequences of her Sjogren's. In particular, she started developing intractable yeast infections of her mouth, esophagus and stomach, making every swallow extremely painful. With her various specialists she has worked her way through all the regular antifungal treatments including infliximab, which caused severe side effects for two weeks out of each eight-week treatment cycle. She travelled to Israel to obtain an experimental medical device to see if that would help and eventually wound up on a new experimental drug protocol—the first patient to receive this treatment in her hospital centre. Her inability to meet her caloric needs has dropped her weight below 90 lbs., so a peripherally inserted central catheter was installed to help provide some additional nutritional support while she undergoes this new protocol.

Her psychiatric evaluation revealed an intelligent, articulate woman with a keen sense of humour and a passion for discussing politics and the state of the world. Her presentation was more consistent with an adjustment disorder than with a major depressive disorder. She was offered supportive psychotherapy which she attended regularly and found quite useful. A heavy smoker, her COPD gradually worsened to the point where shortness of breath began to contribute a significant level of anxiety to her overall clinical picture. She started to escalate in her use of narcotics and sleep medications to try to control her pain and obtain some rest, and eventually had to be admitted briefly for detoxification. She made repeated requests for antidepressants but accepted that they would probably be of little use and would significantly worsen her Sjogren's symptoms.

About one year ago her husband suffered a stroke, then a myocardial infarct while hospitalized. He was eventually able to return home but requires considerable assistance. This was a turning point for Ms. E and was when she began to ask for MAID. She framed it as a result of a confluence of factors: she was constantly in pain due to an untreatable illness and had limited options to control it; her husband would need to be placed in a supported living resource in the near future anyway and would be well taken care of; her children were stable and happy; and she had lived a full life herself and felt she had nothing to look forward to. With her COPD she could no longer go on outings, and with her failing eyesight she was less able to engage in her passion of reading. She was concerned that with her label of “depression” her wish would be interpreted as a suicide equivalent and that she would be denied access to MAID because of this.

Somewhat reluctantly, several of her doctors assisted her in the process of applying for MAID, which we discovered was more complex since she was living at home and not hospitalized. The initial evaluation of her case concluded that she did not meet the criteria for MAID as established in Quebec because she was not imminently dying—she was not considered to be “at the end of life” nor had the “natural death ... become reasonably foreseeable”. She was offered an episode of continuous palliative sedation to see if this might break her pain cycle, and she readily accepted hoping that she might “accidentally” die during the procedure. When she woke 24 h later, she was even more dismayed because this seemed to confirm that she was not, in fact, so medically fragile as to be considered near death, confirming her ineligibility for MAID. She felt dismayed that, in her words, she was “forced to continue to suffer” with little chance at a good quality of life. While remaining reluctant to consider suicide, she researched how to do it with medications at her disposal. She, however, did not go further in her research, fearing that if the attempt went wrong, she would be potentially

handicapped and even less able to advocate for MAID in the future when her condition deteriorates further.

During the following months, Ms. E's condition deteriorated significantly: she developed severe pain in both her legs due to peripheral artery disease, which was inoperable with no alternative solution to relieve her. Her COPD worsened considerably and, while she was no longer as prone to yeast infections, she still suffered crippling odynophagia. This led to a significant weight loss, her weight going below 80 lbs. Ms. E was admitted to a geriatric hospital in that context and, several months after the initial refusal, she was deemed eligible to MAID. Her cognitive functions remaining completely intact, she planned everything herself. She contacted certain of her doctors, including her treating psychiatrist who she asked to see few times before she received MAID. During those appointments, Ms. E was not found to be depressed; if anything, she was relieved and remained in that state until her death. To the extent of our knowledge, her mental condition and mental health treatment did not figure in the decision at all in that her treating psychiatrist was never contacted for any opinion by the doctor doing the procedure. Of course, she was on no psychiatric medication but still received prolonged follow-up, mainly for supportive interventions. Ms. E was not diagnosed with Major Depression or another major psychiatric disorder at the time of her MAID request and death.

3. Discussion

The following section will discuss different questions raised by the cases of Ms. D and Ms. E with respect to the provision of MAID in the Province of Quebec. On the one hand, the case of Ms. E depicts an elderly woman who, despite having been functional all her life, endured significant distress related to her multiple chronic medical conditions and who had little if any ongoing psychiatric comorbidity other than a previous diagnosis of adjustment disorder made during the evaluation of a suspected, but ultimately not present, major depressive disorder. On the other hand, Ms. D is a relatively medically healthy young woman who is struggling with many comorbid mental disorders related to her past repeated traumas. While these two patients differ greatly in terms of demographics and the origin of their distress, they both presented to their psychiatrist a request for MAID that was motivated by significant psychic suffering. Using insights from these two cases as well as Canadian case law and emerging literature on the provision of MAID in Quebec, this section will discuss the management of requests for MAID in a psychiatric outpatient setting via two interrelated themes: the end-of-life criterion, and psychic suffering.

3.1. End-of-life criterion

The treating psychiatrist of both Ms. D and Ms. E felt that these patients did not meet the end-of-life criteria included in both Quebec and Federal laws. On the one hand, Ms. D was definitely not at the end of life: she was 35 years old and did not have any active life-threatening medical comorbidities. On the other hand, Ms. E's case was much less clear, which translated into her receiving different opinions during her journey regarding her eligibility for MAID. Ms. E was an 85-year-old lady who was suffering from COPD and Sjogren's syndrome with related chronic pain as well as severe claudication due to peripheral artery disease. While Quebec's legal framework remains silent as to how to interpret its end-of-life criterion, the federal government has given some guidance to help understand the wording in a clinical setting:

“Natural death has become reasonably foreseeable” means that there is a real possibility of the patient's death within a period of time that is not too remote. In other words, the patient would need to experience a change in the state of their medical condition so that it has become fairly clear that they are on an irreversible path toward death, even if there is no clear or specific prognosis (Department of Justice of Canada, 2016).

The use of the words *not too remote* is of minimal utility in clinical settings given its vagueness, especially when the government specifies afterwards that no clear or specific prognosis has to be made. Despite that, it is still enough to exclude clear cases such as Ms. D's who is fairly young and has no medical conditions that could make her life expectancy significantly shorter than that of the general population. However, Ms. E remains in the grey zone on the sole base of this notion that death should not be *too remote*. She is 85 years of age and a smoker with several medical comorbidities who has already exceeded the average life expectancy for Canadian women (Statistics Canada, 2017). This brings us then to the use of the words "fairly clear that they are on an irreversible path toward death." This implies that there must be some predictability and linearity in the decline toward death. Therefore, rather than being about the medical prognosis itself, which is routinely difficult to render accurately, the end-of-life criterion in the Federal law is more about the process of dying or the irreversible and linear character of the decline of a patient's vital functions. We can argue that, at first, Ms. E's conditions were not progressive enough or severe enough to meet this idea of irreversible and linear decline—for example, let us recall that she was able to survive her episode of palliative sedation despite her COPD. However, when her functioning and suffering significantly worsened due to the progression of her COPD and the addition of symptomatic peripheral artery disease, it seems that the state of irreversible and linear decline became clearer, which then led physicians to reconsider her eligibility for MAID. Moreover, being at the end-of-life is not only about one's medical conditions as per the government of Canada:

Each person's circumstances are unique, and life expectancy depends on a number of factors, such as the nature of the illness, and the impacts of other medical conditions or health-related factors such as age or frailty (Department of Justice of Canada, 2016).

Therefore, while medical conditions are indeed an undeniable factor in the assessment of the foreseeability of someone's death, patients always have to be evaluated holistically. There was one case that went before the Ontario Court where those non-medical factors played an important part in the ruling. AB was a patient in her late seventies who was suffering from chronic pain secondary to severe osteoarthritis which she had been battling for over 25 years. She sought the court's help in the context of disagreement between her physicians as to whether she met the foreseeable death criterion included in the federal law. Her clinical condition was described as follows:

AB's current condition is that she is in an advanced state of incurable, irreversible, inflammatory and erosive osteoarthritis. Her medical condition is not imminently terminal. She is immobile due to constant arthritic pain and cannot perform daily tasks. Her pain is intense, despite every effort of her physicians to manage the pain, which she experiences in her knees, hips, back, stomach, fingers, and toes. She frequently wakes up screaming in pain. Her esophagus has constricted, and it is painful to eat and to swallow medication. She recently suffered from pneumonia. Her condition will worsen. There are no further treatment options. She feels that she has no future other than to live in pain until allowed to die. [22, paragraph 31].

In paragraphs 79 to 84 of his discussion and analysis, the judge mentioned following relevant points that help understanding better the federal criterion of reasonably foreseeable natural death:

In this regard, the words ["natural death has become reasonably foreseeable"] are modified by the phrase "taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining." This language reveals that natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.

Although it is impossible to imagine that the exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course, have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.

In referring to a "natural death" the language denotes that the death is one arising from causes associated with natural causes; i.e., the language reveals that the foreseeability of the death must be connected to natural causes, which is to say about causes associated with the functioning or malfunctioning of the human body. These are matters at the core if not the whole corpus of medical knowledge and better known to doctors than to judges. The language reveals that the natural death need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances.

The Attorney General, in introducing Bill C-14, described the meaning of the words in s. 241.2 (2)(d), and in my opinion, she correctly said that the language does not require that people be dying from a terminal illness, disease or disability.

As the Attorney General said, the language of s. 241.2 (2)(d) encompasses, on a case-by-case basis, a person who is on a trajectory toward death because he or she: (a) has a serious and incurable illness, disease or disability; (b) is in an advanced state of irreversible decline in capability; and (c) is enduring physical or psychological suffering that is intolerable and that cannot be relieved under conditions that they consider acceptable.

These criteria or factors are all matters with which Physician-1 and all physicians are, on an everyday basis, capable of forming opinions on. Physician-1 and all other physicians are equally capable of determining whether the criteria or factors are not satisfied because a natural death is not reasonably foreseeable. (Ontario Superior Court of Justice, 2017)

After this discussion and analysis, the judge finally declared in paragraph 89 that "in accordance with the proper interpretation of s. 241.2 (2)(d) of the *Criminal Code*, AB's natural death is reasonably foreseeable" (Ontario Superior Court of Justice, 2017). While we don't have direct access to the assessment of the geriatric team who provided MAID to Ms. E, it appears that they had the same assessment of our patient: both AB and Ms. E were of advanced age and suffering from chronic pain and other comorbidities that impair quality of life. At first, Ms. E did not meet the end-of-life criterion given that despite being older than AB she remained functional, was able to care for herself, and was not frail enough to be considered to be on a clear and linear path toward death. In other words, the degree of reduction in quality of life and capability was in some ways less in the case of Ms. E than in the case of AB. As the judge mentioned in AB paragraph 83, one element of the reasonably foreseeable death is being in an advanced state of irreversible decline. This might be why AB was deemed meeting the federal foreseeable natural death criterion while Ms. E did not meet it, at least initially. Once her COPD worsened and she developed symptomatic peripheral artery disease however, the assessment of Ms. E changed to the point where she became, in the eyes of several physicians, eligible for MAID. It is interesting to note that while it is possible to make relative judgments between these two cases—or even the three cases of AB, Ms. E's denied request and Ms. E's accepted request, we still lack a standard to compare these cases to. Does the case of AB constitute the standard amount of frailty, decline in capability and reduction in quality of life needed to qualify for MAID at an advanced age, or will some new standard be developed in light of which both AB and Ms. E at the time of her first request will be seen to be eligible? In short, the interpretation of the end-of-life criterion remains complex and imprecise. Some cases such as Ms. D clearly do not meet this criterion, but

others like that of Ms. E might lead to much more difficult, and sometimes contradictory interpretations. Then comes the question, are the legislator and the court putting too much faith in the ability of clinicians in determining the vital prognosis of complex patients? What is the amount of uncertainty and contradictions that is acceptable when assessing eligibility for MAID?

It is also important to remember that a patient's eligibility will change quite sensibly as time passes. Moreover, as we noted previously, the nature of the end-of-life criterion may also evolve over time. The expected timing of death was not explicitly mentioned in the Supreme Court of Canada's *Carter* ruling and, in fact, during the few months prior to the federal law coming into force, people in provinces other than Quebec could request MAID under the Supreme Court's set of criteria alone (Supreme Court of Canada, 2016). During this period, an Albertan man living with amyotrophic lateral sclerosis was granted MAID despite not being imminently dying (Alberta Court of Queen's Bench, 2016), and EF, a patient solely suffering from conversion disorder (a psychiatric illness), was deemed eligible for MAID by the Alberta Court of Appeal, the highest court of the province, only one step below the Supreme Court of Canada (Court of Appeal of Alberta, 2016). The Supreme Court of Canada has never directly assessed the new legal regimes in place in Quebec and Canada and there is still ongoing debate as to whether the end-of-life criterion that excludes de facto most psychiatric disorders is constitutional (Lemmens et al., 2018; McMorro, 2018). At this point, Quebec's End-of-Life Care Act and Canada's Medical Assistance in Dying Act remain in force and have effectively tightened the eligibility for MAID relative to what was acceptable when only the Supreme Court criteria were being used to judge eligibility. In the preliminary evidentiary motions of the *Truchon* case (on which a final decision has not been made yet at the time of writing), the Superior Court of Quebec stated that the Supreme Court of Canada has not assessed yet the constitutionality of the new laws regulating MAID throughout the federation. The judge also stressed that the regime's complexity reflected the compromise legislators made to reconcile the diverse interests and important social values at stake (Superior Court of Québec, 2018). As such, it is unclear if the *Carter* decision's broader eligibility criteria are in fact appropriate for the judgment of other cases, further complicating any legal challenges to the current federal and provincial laws on the basis of their discordance with *Carter*. In addition, the Superior Court of Quebec further mentioned in *Truchon* that the assessment of a law under the *Charter* has to be contextualized and therefore must not be analyzed in a factual vacuum, meaning that challenges to the federal and provincial laws may not be as simple as the demonstration of a discordance between these and the *Carter* decision. Furthermore, the Supreme Court of Canada mentioned in *MacKay v. Manitoba*:

Charter cases will frequently be concerned with concepts and principles that are of fundamental importance to Canadian society. For example, issues pertaining to freedom of religion, freedom of expression and the right to life, liberty and the security of the individual will have to be considered by the courts. Decisions on these issues must be carefully considered as they will profoundly affect the lives of Canadians and all residents of Canada. In light of the importance and the impact that these decisions may have in the future, the courts have every right to expect and indeed to insist upon the careful preparation and presentation of a factual basis in most Charter cases. The relevant facts put forward may cover a wide spectrum dealing with scientific, social, economic and political aspects. Often expert opinion as to the future impact of the impugned legislation and the result of the possible decision pertaining to it may be of great assistance to the courts. [...] Charter decisions should not and must not be made in a factual vacuum (Supreme Court of Canada, 1989).

Therefore, it is unclear if what was decided in the *Carter* case really applies to psychiatric patients. As mentioned in the *Carter* decision, “[t]he scope of this declaration is intended to respond to the factual

circumstances in this case [i.e., Gloria Taylor's case, who suffered from amyotrophic lateral sclerosis]. We make no pronouncement on other situations where physician-assisted dying may be sought” [3, paragraph 127]. Given this statement, are the facts in the cases presented in this article similar to or very different from those in *Carter*? Psychiatrists and other mental health clinicians have a duty to bring the facts to the Court and governments to help them understand the reality of mental healthcare in order to respect, protect and fulfil the fundamental rights of patients suffering from psychiatric disorders. Especially given how much the court and the legislator rely on the professional expertise of clinicians for the determination of eligibility for and the provision of MAID in Canada. It will therefore be of utmost importance that mental health professionals be involved when the Court reassesses the constitutionality of the end-of-life criteria.

3.2. Psychic suffering

Given that MAID's main purpose and justification is to alleviate intolerable suffering, addressing this suffering is central to the management of patients requesting MAID. In fact, both Quebec and Federal laws require that patients be enduring irreversible and unbearable suffering to be eligible for MAID and specify that this suffering can be both physical and psychological in nature (Canada, 2016a; Quebec, 2014). Interestingly, the French version of the End-of-Life Care Act uses the words *souffrance psychique* (psychic suffering) rather than *souffrance psychologique* (psychological suffering). As per Gupta, Rivest, Leclair, Blouin, and Chammas (2017), psychic suffering encompasses all different types of suffering that are not physical in origin (e.g., psychological, existential, social, spiritual...) (Gupta et al., 2017). It seems appropriate to us to assess the suffering at the end of life as being comprised of all these different components rather than only considering the physical and psychological domains. It is also important to note that all dimensions of suffering influence each other (Gupta et al., 2017). For instance, it is well known that anxiety and depression worsen physical pain (Scott et al., 2016). Of course, one might argue that all psychic pain—i.e. that pain which may relate to the existential or spiritual, among other domains—is, essentially, psychological pain as all of these phenomena—spirituality, existential questioning, etc.—are experienced in the mind. We chose to use the word ‘psychic’, however, out of deference to existing literature cited above and also out of a desire to remind the reader that the pain we are considering under the umbrella of psychic pain encompasses more in scope than that which is ‘traditionally’ associated with psychological pain in the minds of most clinicians (i.e. symptom categories).

Both Ms. D and Ms. E experienced psychic suffering, and this played a major role in their desire to hasten their death through MAID. Ms. D endured hopelessness without the capacity to function as she wanted to in life and was continuously haunted by her past traumas. Ms. E presented significant existential suffering, finding she had nothing to look forward to and no reason to remain alive while facing worsening chronic pain; she was also on the verge of losing one of her last remaining pleasures—reading—because of her failing eyesight. There is no doubt both patients received very good and extensive psychiatric care for their psychological suffering as well as excellent medical care for their physical comorbidities. As such, neither of these patients could be said to be choosing to request MAID because of lack of access to better options; this is important because a common concern with respect to MAID is that patients who cannot get access to optimal care because of the healthcare system's failure to provide it or because of personal economic disadvantage may end up requesting MAID as a more accessible alternative to reduce their suffering (Quebec Court of Appeal, 2018). However, as mentioned previously, psychic suffering is broadly defined, and the treatment required is most likely broader than simply the provision of excellent medical or psychiatric care. For example, existential suffering, which is related to losses and dearth of meaning might not be alleviable by standard psychiatric care alone

(Gupta et al., 2017). Existential therapy, psychodynamic therapy, or counselling by a religious figure may be useful complementary approaches. In terms of social suffering, we already know that social isolation is a major predictor of requests for hastened death (Kim, De Vries, & Peteet, 2016). While psychiatrists are generally experienced in supporting patients at the individual level, they may not always be empowered to alleviate systemic and social factors. Family therapists and social workers should also be involved to help deal with loneliness and isolation; public health professionals have been looking at how to improve loneliness at the societal scale, with the United Kingdom having recently appointed a minister for loneliness (BBC, 2018). As the prevention of social isolation is currently a challenge in our societies and as resources for the treatment of many facets of psychic suffering are not always readily available, should MAID be extended to patients with exclusively psychiatric disorders, a comprehensive treatment program for psychic suffering, addressing the psychological, social, existential and spiritual domains should be developed and implemented. It will be important for this approach to be interdisciplinary and to include a public health and prevention component in order to reach the large segments of the population that are struggling with loneliness and other aspects of psychic suffering (Canada, 2016; Holt-Lunstad et al., 2015; Institut national de santé publique du Québec, 2015). This is critical because otherwise current healthcare systems, with their lack of resources for the comprehensive alleviation of psychic suffering, may lead to more death than necessary among vulnerable patients, such as psychiatric patients, by providing MAID without the provision of comprehensive alternative options for reducing psychic suffering. Without these resources in place, it may be difficult to determine if many patients who request MAID truly meet the treatment resistance criterion for eligibility for MAID. The law requires that patients be resistant to treatments acceptable to them to be eligible for MAID; but if the treatment they need—that is, treatment beyond usual psychiatric and medical care—was simply not offered, how can we be certain that they are, in fact, resistant to treatment to the point that they are to be considered eligible for a hastened death?

Returning to the cases of Ms. D and Ms. E, it is clear that both of these patients experienced psychic suffering; however, both of them also arguably had access to resources that alleviated this suffering. Both were enrolled in comprehensive care programs which included access to a diversity of professionals including social workers and therapists; Ms. D found a passion in the arts and was actively studying graphic design, and Ms. E was well supported by her family and treating team, and was, until her eyesight began failing, able to enjoy reading. Nevertheless, Ms. E still requested MAID a second time—and was granted MAID when her medical condition worsened. Therefore, we can assume her psychic suffering remained present since her desire to hasten her death persisted despite all the efforts of her treating team. This illustrates how important it is to assess if the efforts to alleviate psychic suffering are sufficient and effective enough to indicate treatment resistance—especially in the context where the end-of-life criterion might be removed. What is concerning is that there is no clear guidance on how to determine if this is the case. Was Ms. E's suffering really intractable? And, should the end-of-life criterion be removed, would Ms. D's psychic suffering be deemed treatment resistant in the eyes of the law, given that extensive psychiatric treatment and access to social and educational programs failed to relieve her suffering? Given the long time to remission of many mental disorders, how much time must pass while efforts are being made to alleviate psychic suffering before a patient is deemed to be treatment resistant? And should a patient relapse, is this to be taken as an indication of intractable suffering, or must the patient be made to retry all previously attempted approaches to the alleviation of psychic suffering which worked in the past? How many specialists must a patient see, and how specialized do they have to be, before their suffering being deemed intractable? Regarding the case of EF, the patient with conversion disorder who had been deemed eligible to MAID by the Alberta Court of Appeal, some

argued that the specialists who could confirm EF's diagnosis and assess the intractability of her suffering (i.e., movement disorder neurologist and neuropsychiatrist) were not contacted (Hurwitz, 2018). This leads to the other question of how specialized someone need to be to deem a person's illness intractable, especially in the context of mental disorders for which intractability can be extremely challenging to determine (The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition, 2018).

While there is no doubt that Mrs. E's psychiatric and medical care was of high quality and everything was done to treat her psychological and physical pain, how can we address the other components of her psychic suffering? Ms. E felt that she has little to look forward to and struggled to find a reason to keep living. Indeed, her existential suffering seemed more prominent than her psychological suffering and in fact she had only been formally diagnosed with an adjustment disorder, one of the milder psychiatric diagnoses. She may therefore have benefited from other types of treatment such as existential or behavioural therapy aimed at finding a new role for herself and creating new meaning in her life while learning to accept the losses she has experienced.

Ms. D, on the other hand, had more severe psychiatric symptomatology and she tried multiple interventions to tackle it: hospitalization, pharmacotherapy, ECT, rTMS, EMDR, and cognitive therapy. Are these failed attempts at treatment sufficient to deem her suffering treatment resistant? Should she have to try other types of therapy, such as psychodynamic psychotherapy or dialectic behavioural therapy? Should she be required to try more experimental treatments, such as deep brain stimulation? In addition, given that failure of therapy can be caused by a mismatch between a patient and their therapist or psychiatrist, should she be required to try a number of different professionals before being considered treatment resistant, and how long should each attempt last? None of the answers to these questions are to be found in current professional guidance or legislation, nor are they clear even on a case-by-case basis. While such answers would have been more welcome when assessing the case of Ms. E, they would become necessary if the end-of-life criterion were to be removed and Ms. D were to make another MAID request. Both patients were willing to try multiple different therapies, and so it is possible that both patients might keep trying different approaches in order to alleviate their suffering. It is possible that one of these approaches may end up working, validating the continued attempts. However, much like there is no hard-and-fast rule for when to end cardiopulmonary resuscitation efforts, it is not clear when a patient has searched 'enough' to be considered to have treatment-resistant psychic suffering.

These two patients are, of course, very different from patients who refuse to try standard treatments, such as electroconvulsive therapy (ECT). While a full discussion of these types of patients is beyond the scope of this paper, it is important to note that psychiatric disorders often cause cognitive distortions (Cusi et al., 2011; Lee et al., 2012; Waford & Lewine, 2010), making treatment refusal difficult to interpret at baseline; if one then adds in the question of MAID and the requirement that treatments *acceptable to the patient* have failed, this picture becomes far more complex. Take for example a depressed patient requesting MAID who would likely benefit from ECT but refuses it. If the ECT would both alleviate the symptoms *and*, post-treatment, change the patient's perspective of ECT and of their illness (as a result of the lifting of the depression), can the patient be deemed to be treatment resistant if they have not tried ECT? Or in this case should patient preference overrule possible therapeutic benefit, even if this preference is being strongly influenced by the depressive state?

Both patients discussed in this article made their request for MAID in an outpatient setting, which leads itself to a very important question: which of the many possible clinicians a patient may be seeing is responsible for handling the MAID request, given that in the outpatient setting there is often not one clinician who is 'in charge' of the case? As previously mentioned in our first case series, the cause of suffering does

not have to be the same as the cause of impending death (Benrimoh et al., 2017). As such, should the clinician handling the request be the one treating the main illness, such as cancer or advanced COPD? Should it be the clinician who most understands, in a holistic way, the patient's suffering (which often will be the psychiatrist, if one is involved)? Or should the physician to whom the request is made first be the one responsible for ensuring the protocol for access to MAID is enacted? This question is especially pertinent to the case of Ms. E who was co-followed by an internist, a respirologist and a psychiatrist; who initially made the request to her psychiatrist and finally received MAID from another team without the psychiatrist who refused the initial demand being contacted for his medical opinion. It is our opinion that a discussion between all involved clinicians would have been optimal, especially given that the physicians assessing the request for MAID were not the ones who had followed the patient for the longest time. Additionally, the law requires that two physicians be in agreement regarding the eligibility for MAID. What would have happened in the case of Ms. E if all the doctors following her had to discuss her eligibility for MAID, and then a disagreement ensued? Who would settle the dispute? How should one weigh the opinions of different specialists? For example, would more weight be given to the clinician who knew her the longest, or would it be to the one who was most intimately acquainted with her present medical condition? At the moment, the law simply requires two agreeing physicians to ensure eligibility for MAID, though it remains unclear to us if this is an optimal state of affairs when the patient is being followed closely by more than two clinicians.

One final point to consider in our discussion is the question of the appropriateness of handling MAID requests primarily motivated by psychic suffering in the context of our existing healthcare system. Not all—and some might argue, relatively few—physicians in our healthcare system feel competent to help patients alleviate psychic pain, as this has simply not been within the purview of medicine or specialized medical training. Many physicians feel that addressing the entirety of the patient is too daunting a task, or simply one they are not responsible for; indeed, concerns about the need to improve the attention of medicine to patient needs beyond the immediately physical or traditionally psychological (in terms of symptoms) are part of the motivation for the holistic care movement (Thomas et al., 2018). Some might even question if caring for patients with psychic suffering falls within the purview of medicine at all, which has traditionally been interested in the curing of identifiable disease. Regardless of one's opinion, it is a fact that, because of the special status that medicine enjoys when it comes to the administration of the kinds of medications and processes which are necessary for MAID—as well as the close relationship between many MAID requests and identifiable illness—medicine as a profession has been saddled with the responsibility of handling MAID cases. As such, the possibility for the ethical administration of MAID, which is usually to be administered in the absence of effectiveness of treatments acceptable to the patient, is called into question if the practitioners offering MAID are not able to offer treatments for psychic pain which may be both effective and acceptable to the patient in question. MAID might then be offered—and carried out—in situations where remedy of psychic pain might have been possible in principle but rendered impossible by the operational context and the competence of the administering physician to provide truly holistic care. Whether this is remedied by transferring MAID decisions to another entity (which is practically unlikely) or by improving the education, skillsets, resources, and scope of practice available to physicians remains to be seen, but the status quo raises serious ethical concerns which should be addressed in some manner in the near future.

4. Conclusion

In this paper we have presented two new cases of patients who requested access to MAID in a psychiatric outpatient clinic. One patient was at an advanced age and suffering from intense physical and psychic

pain with little if any psychiatric comorbidity. The other was young and medically healthy but was suffering from extensive psychiatric comorbidity. Both had been through extended periods of treatment, and both were unwilling to commit suicide because of the risk of failure and increased suffering as a result of possible injury. As such both patients viewed MAID as a way to end their suffering in a safe and secure manner. Neither patient was granted access to MAID by their outpatient mental health treating team as they were not considered to be at the end of life and in a state of irreversible decline, however, one of them finally received it from other physicians in the context of a worsening medical state. Their cases illustrate several important issues. One is the importance of addressing psychic suffering holistically and the need for improved resources for dealing with non-medical sources of suffering such as social isolation. Another is the lack of a clear definition of treatment resistance given the expanded array of interventions needed to adequately address psychic suffering. Finally, they raise the issue of which clinician should be in charge of a MAID request when an outpatient is being followed by multiple physicians. These questions have no easy answers but are critical for the psychiatric community to debate and discuss in the context of evolving laws and legal precedent around MAID in Canada.

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