Brief for the Special Joint Committee on Medical Assistance in Dying
Parliament of Canada

The government should not permit MAiD for mental disorders and must make capacity assessments a Criminal Code requirement for all MAiD

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My father, John Lyon (1), was euthanised[1] in Victoria, BC, possibly with alcohol (by "special permission") and hydromorphone in his system, which individually and together impairs capacity. He had a history of suicidality and depression and was in acute crisis and suicidal when he found MAiD. To my knowledge, he was not formally assessed for his capacity to consent to his death.

In healthcare, capacity to consent is the ability of a person to understand, retain, and communicate the relevant information, including consequences, for a specific decision. It is integral to autonomy (2). Current bioethical standards assume every adult has capacity, but rigorous evaluations may be required for mental disorders given the greater risk of capacity problems (3). Capacity assessment rules vary somewhat across Canada, such as when, who, and by whom someone can be assessed. Only certain clinical occupations with special training can do them, and they sometimes need other experts, family members, and several visits with the patient.

Capacity worries around Canadian MAiD are well-known (4). Red flags were raised in 2016 (3) (when MAiD was first legalised) about the challenge of capacity assessments, which involve "applying broad criteria to complex clinical situations" but that "training…was suboptimal," especially in psychiatric cases (3). Canada's experts lacked the medical, legal, and bioethical knowledge and methods for capacity assessment appropriate for the high-risk life and death decisions in MAiD for mental disorders (5).

Despite these grave concerns about shortcomings, little research exists on Canadian MAiD capacity test use. However, a study (6) interviewed 20 MAiD practitioners in late 2019 and early 2020, accounting for only 1.8% of the 1112 practitioners noted active by early 2020 (before Bill C-7 MAiD) (7). These 20 clinicians disproportionately completed "2410 assessments…during a period in which there were about 10 000 MAiD deaths in Canada,"[2] but

[1] Though technically legal outside Quebec, **self-administration is often unavailable** provincially or locally. Euthanasia is often the only *choice* for MAiD.

[2] This highly concentrated distribution of assessments among assessors aligns with the concentration of deaths among providers reported by Health Canada (7). Converting the percentages in the Health Canada fourth, and

mostly avoided formal clinical capacity assessments and relied instead on their "experience," "conversations," "gut," or "intuition" - even for non-verbal patients (*6*). When undisclosed, such informal "probing" is ethically and legally worrisome as it undermines patient autonomy and informed consent (*8*). A participant considered rare formal capacity tests "rigmarole" to protect themself (no mention of the patient!) if deaths were questioned (*6*). Especially concerning MAiD for mental disorders, the non-psychiatrists in this study mostly had no experience with psychiatric-only cases. Still, they may have assessed people with comorbid physical and mental illnesses for which MAiD is permitted. It is shocking then that MAiD providers are even reported to discuss or admit to sedating patients, perhaps "covertly," to lower their capacity to refuse death (*9*).

Thus, many or most deaths may happen without any formal capacity test. Indeed, Québec's MAiD commission identified three deaths of incapacitated patients that breached MAiD consent laws at the time (*10*). Other provinces and territories lack or have only just announced such oversight bodies, so homicides elsewhere may go undetected.

Reasons might be that whilst MAiD assessments take 1 - 2 hours (*11*) (in person or telehealth), capacity assessments for mental disorders are more involved and lengthier, and some clinical staff feel MAiD is already bureaucratically burdensome (*12*). Psychiatry, the eligible assessor specialism best suited to assessing capacity in mental disorders, accounts for just 0.8% or 15 of the 1837 MAiD providers in 2022, while non-specialist family and nurse practitioners account for 77.1% (*7*). Psychiatrists also repeatedly warn that irremediability in mental disorders is virtually impossible to predict reliably (*13*).

Clinically recognised formal capacity assessments in MAiD do not seem routine. Alarmingly, some MAiD clinicians appear to have unverified confidence in their informal skills, may view capacity itself as an obstacle to MAiD, and persons without the capacity to consent are known to have been killed. The lax, perhaps hostile, attitude to capacity assessments from some prolific MAiD assessors imperils all requestors, especially those with mental disorders.

To protect patients from abuses or errors due to these attitudes, MAiD should not be permitted solely for mental disorders. Further, the Criminal Code should require mandatory independent capacity assessments by well-trained and vetted mental health professionals for all MAiD applicants. This is to safeguard people with both mental disorders and MAiD-eligible physical illnesses.

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previous, annual MAiD report's (*7*) section 5.3 shows that **the small minority of providers with 10 or more deaths (18.3 % is just 336 of 1837 providers in 2022) most likely provide well over 50 % of all MAiD deaths.**

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