Medical Assistance in Dying for Mental Disorders

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Medical assistance in dying (MAiD) has emerged as one of the most ethically complex and emotionally charged developments in modern healthcare. Originally intended to relieve the intolerable suffering of terminally ill patients through voluntary euthanasia and physician-assisted suicide, MAiD is now used in some countries, such as Belgium, for individuals with severe psychiatric conditions deemed irremediable and unlikely to improve. This development raises critical questions about consent, capacity, and the definition of irremediable suffering. Since the passage of Canada's Bill C-14 in 2016, which legalized MAiD for individuals with grievous and irremediable conditions nearing the end of life, ongoing discussion has emerged around extending eligibility to those with psychiatric disorders. In contrast, Belgium has permitted MAiD for psychiatric illness under strict criteria since 2002. This paper explores the legal, ethical, and clinical dimensions of MAiD for psychiatric patients in addition to how healthcare providers, especially Physician Assistants, can navigate this complex topic through compassionate, evidence-based, and ethically grounded care.

The Canadian Parliament enacted Bill C-14 in 2016, legalizing MAiD for capable, consenting adults with a serious disease, illness, or disability that causes irreversible decline, intolerable physical and/or psychological suffering, and whose natural death is reasonably foreseeable (Coelho et al., 2023). MAiD has several safeguards to ensure that the practice is ethically executed. There must be a 90 day period between the first assessment and MAiD provisions. This lapse may be shortened if the person is at risk of imminent loss of capacity to consent to the procedure. Additionally, eligibility must be confirmed by two independent physicians or nurse practitioners, and a specialist in the patient's condition should be consulted. Patients must also demonstrate that they have seriously considered alternative means of relieving their suffering. Lastly, patients have the option to withdraw their request for MAiD at any time (Bastidas-Bilbao et al., 2024).

Canada had planned to expand MAiD eligibility in 2023 to individuals whose sole underlying medical condition is a severe psychiatric disorder. However, this expansion was postponed to 2024 due to widespread public and professional backlash (Bastidas-Bilbao et al., 2024). A key concern was that doctors perhaps may not be able to reliably predict whether a mental illness is truly irremediable and incapable of improving, which is a legal requirement for MAiD eligibility. In addition, there were fears

that individuals experiencing an acute, potentially temporary mental health crisis could be inappropriately approved for MAiD, despite the possibility of recovery with appropriate treatment and support (Coelho et al., 2023).

Unlike Canada, Belgium permits MAiD for severe psychiatric cases. In 2002, Belgium passed legislation allowing MAiD for legally competent adults experiencing unbearable physical or mental suffering due to incurable conditions, including psychiatric illnesses. To be eligible, the request must be voluntary, repeated, well-considered, and free from external pressure. The patient must have a condition with no prospect of improving and must experience constant and unbearable mental suffering that cannot be alleviated. For psychiatric MAiD, in addition to the above, the patient must be struggling with a serious and incurable psychiatric disorder (De Hert et al., 2024). When MAiD is requested solely on psychiatric grounds, Belgian law requires the attending physician to reach a "level of mutual understanding" with the patient regarding the nature of their suffering. This determination is highly individualized, taking into account the patient's mental resilience, personality, and unique experience of suffering. For patients who are not terminally ill, the law mandates evaluations by two additional physicians, one of whom must be a psychiatrist or a specialist in the specific disorder, to assess the patient's mental capacity and suffering within the context of their psychopathology (Verhofstadt et al., 2017).

A central challenge in the debate over MAiD for psychiatric disorders is whether psychological suffering can be considered truly "terminal". A growing body of research supports the view that unbearable psychological suffering, even when not linked to terminal illness, can reach a level of severity that prompts rational and sustained requests for MAiD. In a qualitative study of 26 Belgian psychiatric patients who requested euthanasia, participants described their suffering as constant, progressive, and irreversible, often viewing their condition as medically or existentially futile. The study identified five overlapping types of suffering: medical, intrapersonal, interpersonal, societal, and existential. Medically, patients reported not only distress from symptoms like anxiety, shame, and dissociation, but also frustration from years of ineffective treatments, misdiagnoses, and poor communication with healthcare providers. Intrapersonal suffering included past trauma, self-destructive behavior, and shame surrounding

failed suicide attempts. Many preferred euthanasia because it offered dignity and peace, unlike the pain and unpredictability of suicide. One participated shared that she "feared surviving another suicide attempt more than dying" (Verhofstadt et al., 2017). Interpersonal suffering stemmed from grief, isolation, and feeling like a burden. One patient reported that "the people around you cannot believe that you want to die, because you're looking so good, so no one would allow you to die" (Verhofstadt et al., 2017). Societal suffering was linked to poverty, unemployment, and feeling "forced to mask" in a society that moved too fast for them. Existentially, patients described a collapse of selfhood; "I feel like a puppet of the medical system, not a person anymore" (Verhofstadt et al., 2017).

Despite their suffering, many patients were thoughtful, self-aware, and capable of articulating a clear rationale for their request. Paradoxically, simply having their request taken seriously by a physician often brought emotional relief. One participant stated "since my request to die was considered to be acceptable, I'm experiencing better moments… I'm still in therapy and we are discussing other options," (Verhofstadt et al., 2017). This finding challenges the belief that all MAiD requests in psychiatric illness stem from impulsivity or distorted judgment. Ethically, this complicates the principle of non-maleficence, as denying MAiD may inadvertently prolong intense, multidimensional suffering. At the same time, it raises important concerns about justice and social responsibility, as some patients requested euthanasia not only because of illness, but because they lacked adequate financial, emotional, or systemic support. These insights underscore the need for careful, individualized evaluation and reinforce the importance of listening with empathy, even when providers are ethically conflicted.

In order to ensure that MAiD is used properly, capacity must be carefully examined and consent must be fully obtained. Both Canada and Belgium emphasize capacity and consent as critical considerations in MAiD eligibility. In Canada, the *Capacity Assessment* or *MacArthur Competence Assessment Tool* are aids that are used to help clinicians determine a patient's capacity to consent to MAiD. The tools involve a medical interview focused on four key elements: understanding information relevant to the condition and recommended treatment, appreciating the nature of the patient's situation and consequences of their decision, reasoning about potential risks and benefits, and the ability to express a clear choice. These four elements help clinicians determine that the patient understands their medical

condition, the recommended treatment, the implications of their decisions, and can clearly express a choice. For example, sometimes a patient's depression might make it difficult for the provider to determine if the patient understands the nature of their condition and the consequences of their choices. In such cases, clinicians can use gentle, probing questions to assess the consistency and stability of the patient's responses over time. Capacity assessment should not rely on a single evaluation by one clinician; rather, at least two independent interviews are required to ensure reliability (Wiebe et al., 2021).

Once it is deemed that the patient has capacity, consent for MAiD is obtained through two steps, initial informed consent and expressed consent. Initial informed consent involves discussing the nature of MAiD, its risks and benefits, and available alternatives like palliative care. Once this is thoroughly discussed, the patient will be able to formally consent to receiving MAiD by signing a request form or submitting a written statement. Lastly, expressed consent occurs immediately prior to MAiD, when the patient is asked for their consent and confirms the consent via a verbal affirmation (Wiebe et al., 2021).

In Belgium, capacity is assessed using the cognitive ability model, which measures the same four elements discussed above for the *Capacity Assessment* for MAiD in Canada: expression of choice, understanding, appreciation, and reasoning. Expression of choice refers to the patient being able to coherently and consistently articulate a wish for euthanasia. Understanding involves the patient being able to grasp relevant facts about their diagnosis, prognosis and available treatments. Appreciation refers to the patient recognizing how those facts apply to their own situation. Reasoning involves the patient being able to weigh alternatives, such as euthanasia vs. continued care, palliative options, and explain their rationale. Unlike in Canada, the *MacArthur Competence Assessment Tool* is rarely used in Belgium. Various requirements are required for obtaining consent. The patient must demonstrably possess decision-making capacity and cannot be legally incapacitated or under a legal guardianship. They must be adequately informed about their condition, prognosis, and treatments, and their MAiD request must reflect the patient's actual and persistent wish. Additionally, if the suffering is psychiatric in nature, the physician needs to obtain an independent opinion from the psychiatrist. Once capacity has been determined, the patient provides consent via a signed and dated formal written request (Schweitser et al., 2020).

Once capacity has been determined and consent has been obtained, MAiD offers an end to suffering of people with terminal illness. However, MAiD can greatly impact the providers that provide this service. A 2022 systematic review of 35 qualitative studies from Canada, the Netherlands, Belgium, Switzerland, and the United States examined the emotional impact on healthcare providers who participated in MAiD. The review revealed that healthcare provider's emotional experiences were shaped by more than just individual beliefs; they are also influenced by their professional roles, national legislation, and cultural attitudes toward death and suffering. The emotional responses described in the studies span a wide range from feelings of fulfillment and moral clarity to deep discomfort, guilt, and internal conflict. Providers working in jurisdictions with broader MAiD eligibility, such as those that do not require terminal illness, often reflect on the experience as part of a philosophical or meaning-making process. In contrast, those practicing in more restrictive legal contexts, like the U.S., reported more intense emotional polarization and moral distress. Nurses, in particular, were found to carry a disproportionate emotional burden due to their close proximity to patients and their dual responsibility as both advocates and caregivers.

The review also points to ongoing ethical and systemic challenges, including unresolved tensions between honoring patient autonomy and preserving the sanctity of life, as well as structural issues like unclear protocols, poorly defined roles, and a lack of coordinated team-based support. The findings emphasize that MAiD is far more than a procedural intervention, it's a morally complex, emotionally taxing process that forces providers to reconsider their understanding of care, responsibility, and what it means to support someone at the end of life.

The impact on providers and the life-ending outcome of MAiD highlights the importance of following an ethical framework when considering this pathway for a patient with psychiatric disorders. "Medical Assistance in Dying for People Living With Mental Disorders; a Qualitative Thematic Review" offers a detailed ethical review of medical assistance in dying for mental disorders (MAiD-MD) organized around six key areas of concern: societal influences, the healthcare system, the continuum of care, conversations around MAiD-MD, MAiD-MD practices, and the quality and oversight of assessments. It

explores how moral concerns emerge within each of these domains and presents a wide-ranging view of the complexities involved in MAiD for psychiatric patients.

In the societal context, stigma, isolation, and poor living conditions may push individuals to request MAiD-MD not because of their illness, but because of life circumstances. These pressures can undermine true autonomy. In the healthcare system, patients often lack access to sustained psychiatric care, housing, and community support, which leaves them without viable alternatives to end of life decisions.

Within the continuum of care, the article highlights breakdowns in therapeutic relationships, loss of hope, and shifting goals of care. Some patients may feel like burdens, which can contribute to their desire for MAiD-MD. In terms of discussing MAiD, healthcare professionals often feel unprepared or conflicted about how to respond. Miscommunication or a lack of empathy during these conversations can intensify a patient's suffering or lead them to withdraw from care entirely.

When examining MAiD-MD practices, the article notes the difficulty of assessing eligibility criteria like capacity, intolerable suffering, and irremediability. Mental illness adds layers of complexity and fluctuating symptoms can cloud decision making. Lastly, concerns about quality and oversight include the risk of bias, lack of psychiatric input, and inconsistent assessments. Safeguards suggested include collaborative decision-making, professional reflection on bias, and documenting all attempted treatment options before approving MAiD-MD. This helps ensure that MAiD is not considered prematurely. PAs should also prioritize team based collaboration, involving psychiatrists and other providers who know the patient well. This reduces individual bias and creates a more balanced, supportive process. To guard against the influence of stigma, PAs must commit to ongoing bias training and self-reflection, particularly in how they interpret suffering and decision-making capacity.

Moreover, MAiD requests should be met not with judgment or defensiveness, but with empathy and curiosity. Even when a patient is not eligible or not yet at the end of their options, acknowledging their pain and opening space for honest dialogue can restore dignity and therapeutic trust. Importantly, PAs should maintain recovery oriented care even during MAiD discussions. Offering hope, safety, and support, while still respecting the patient's autonomy, can shift the trajectory of care toward life, even

when death is on the table. Finally, PAs should advocate for systemic improvements like better access to palliative psychiatry, housing, and community-based mental health services, which can address the root causes that often make MAiD feel like the only option.

In practical terms, PAs can implement these recommendations by routinely integrating comprehensive treatment reviews into patient assessments, ensuring no potential therapy or support option is overlooked. Establishing regular multidisciplinary meetings with psychiatrists, social workers, and therapists fosters collaborative decision-making and shared responsibility. PAs should also seek out or advocate for training programs focused on recognizing and managing stigma, enhancing communication skills around sensitive topics like MAiD, and developing cultural competence. Creating safe, nonjudgmental spaces during consultations encourages patients to express their feelings openly, which can reveal underlying needs or shifts in treatment goals. Finally, PAs can play a vital role in connecting patients with community resources, such as housing assistance, peer support groups, and palliative psychiatry services, to address social determinants of health that often contribute to despair. These steps not only support ethical MAiD practices but also reinforce recovery-oriented care that values the whole person.

As MAiD evolves to encompass psychiatric disorders, healthcare providers are faced with unprecedented moral, clinical, and systemic challenges. While legislation in Canada and Belgium offers structured frameworks for assessing capacity and consent, the deeply personal and societally inflected nature of psychological suffering greatly complicates these evaluations. For PAs, ethical practice in MAiD requires balancing procedural requirements with empathy, clinical judgment, and collaboration across disciplines. MAiD should never be seen as a shortcut through suffering, but as a final option only after all viable avenues of care and support have been genuinely exhausted. Ultimately, by balancing compassion with caution, Physician Assistants can honor patient autonomy while upholding their profession's ethical principles and protecting the dignity of the most vulnerable individuals they serve.

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