MEDICAL ASSISTANCE IN DYING (MAID) FOR CANADIANS WHOSE SOLE UNDERLYING CONDITION IS A MENTAL DISORDER: AN EXAMINATION OF THE VALIDITY OF THEIR AUTONOMY.

By

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Abstract

Canadians with a mental disorder as their sole underlying condition (MDSUMC) are still unable to access medical assistance in dying (MAiD). This is due to the sunset clause in bill C-7 that temporarily prohibits MAiD MDSUMC until March 17th, 2024. Proponents of MAiD MDSUMC argue that prohibiting all Canadians with a mental illness from accessing MAiD violates their autonomy. This thesis challenges this argument, asserting that the autonomy of a significant portion of Canadians with mental illness is not valid due to the significant barriers to mental health care that reduce the voluntariness of their requests for MAiD. It also argues for the paternalistic prohibition of MAiD MDSUMC to ensure proper evaluation of the voluntariness of MAiD decisions.

The argument is laid out in four chapters. The first chapter traces the legislative evolution of MAiD in Canada. It also describes the burden of mental illness and the state of mental health care in the country. It explores two barriers to mental health care: long waiting times and stigma. Chapter two establishes a link between the two barriers of interest and intolerable suffering, a core aspect in evaluating MAiD requests. Chapter three demonstrates how, by worsening the experience of mental illness to intolerable proportions, the two barriers diminish the autonomy of Canadians with MDSUMC regarding their MAiD decisions. It employs the socio-relational notion of autonomy to present this argument. The final chapter defends the paternalistic prohibition of access to MAiD MDSUMC. It argues that paternalism is justified when there are sufficient reasons to suspect autonomy failure, which occurs when an individual is stopped from pursuing their authentic goals or is forced to alter them. It asserts that the barriers to mental health care a strong enough factor to alter the goals of Canadians with mental illnesses.

General Summary

Canadians with mental illness as their only condition are prohibited from seeking medically assisted death (MAiD). Some organizations argue that this prohibition goes against their rights, specifically the right to decide what happens to their bodies. This thesis disagrees with that position. It counterargues that many Canadians with mental illnesses face big obstacles in getting mental health care. These obstacles can make their suffering unbearable and force them to seek MAiD, which raises questions about the ethical plausibility of honoring decisions that people have been coerced to make.

The thesis is written in four chapters. Chapter one outlines the history of MAiD in Canada and the obstacles to mental healthcare. Chapter two connects the obstacles to unbearable mental suffering, an important factor in assessing MAiD requests. Chapter three shows how these obstacles make it hard for Canadians with mental illness to freely choose MAiD. Lastly, chapter four argues for the restriction of access to MAiD for Canadians with mental illness to ascertain the voluntariness of their requests.

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Abbreviations

ALS – Amyotrophic Lateral Sclerosis

BCCLA- British Columbia Civil Liberty Association

CAMH – Centre of Addictions and Mental Health

CIHI- Canadian Institute of Health Information

CMA- Canadian Medical Association

CPA- Canadian Psychiatric Association

DSM- Diagnostic and Statistical Manual of Mental Disorders

MAiD – Medical Assistance in Dying

MDSUMC – Mental Disorder as the Sole Underlying Medical Condition

OECD - Organization for Economic Co-operation and Development.

PHAC- Public Health Agency of Canada

SCC – Supreme Court of Canada

WHO- World Health Organization.

Introduction.

In September 2019, Justice Christine Boudoin of the Superior court of Quebec struck down the requirement that one's death should be reasonably foreseeable to be eligible for Medical Assistance in Dying (MAiD) (Canada, 2021). While her ruling was not related to mental illness, it made it easier for Canadians with a mental disorder as the sole underlying condition (MD-SUMC) to be eligible for MAiD. This ruling preceded Canada's amendment of its MAiD law to avail the service to those with MD-SUMC starting in March 2024.

Two in three Canadians agree that individuals with mental illness should be allowed to access MAiD if they meet all other criteria and have the capacity to provide informed consent (IPSOS & Dying With Dignity Canada, 2021). Proponents of MAiD MDSUMC argue that prohibiting all Canadians with mental illness from accessing MAiD violates their autonomy and is premised on a pejorative notion that they are incapable of making well-considered decisions about their lives (Dying with Dignity, Canada, 2021).

This thesis challenges the argument that excluding Canadians with mental illness from MAID violates their autonomy. It argues that the autonomy of a substantial number of Canadians with mental illness regarding MAiD decisions is not valid due to the significant barriers to mental health care that reduce the voluntariness of their requests for MAiD. The thesis explores the impact of two main barriers to mental health care: long waiting times and stigma associated with having a mental illness. It argues that these barriers worsen the experience of mental illness to the point of making it intolerable, effectively coercing many Canadians with mental illness into requesting MAiD. It also argues that the two barriers constitute sufficient reasons for paternalistic prohibition of MAiD MDSUMC. This is necessary to ensure proper evaluation of the voluntariness of MAiD MDSUMC decisions.

Thesis outline

The thesis is structured into four chapters, each building on the foundation established in the previous one. Chapter one traces the legislative evolution of MAiD in Canada, presents the burden of mental illness, and the state of mental health care in the country. This chapter also explores the prevalence of the two barriers of interest: long waiting times and stigma. Where applicable, the state of these barriers is compared with other countries that have similar health systems and permit MAiD to those with MD-SUMC.

Chapter two establishes a link between the barriers of interest and intolerable suffering, an essential factor in assessing MAID requests in Canada and other jurisdictions where MAID MD-SUMC is legal. It presents evidence of the negative impact of stigma on help-seeking and the experience of mental suffering, as well as the effect of extensive waiting on treatment outcomes. The purpose of this chapter is to demonstrate how these barriers worsen the experience of mental illness and increase the likelihood of intolerable suffering.

Chapter three demonstrates how, by worsening the experience of mental illness to intolerable proportions, the two barriers diminish the autonomy of Canadians with MD-SUMC regarding their MAiD decisions. It does not examine the psychological competence of Canadians with mental illness, but rather the impact of these barriers on the voluntariness of their decisions. The argument for the autonomy-diminishing effect of these barriers rests on the socio-relational notion of autonomy, which holds that autonomy is exercised within the complex web of our social-relational health determinants. Additionally, this chapter launches a critique of the contrasting view of autonomy as individualistic.

Chapter four defends the paternalistic prohibition of access to MAiD MD-SUMC. It argues that soft paternalism is justifiable if there are sufficient reasons to suspect autonomy failure, which occurs when one is stopped from meaningfully pursuing their authentic goals or is subjected to conditions that alter them. The chapter asserts that inadequate access to health care and stigma are strong enough reasons to alter the goals of Canadians with mental illness, and that paternalistic interference is justified to ascertain the voluntariness of their MAiD decisions.

Chapter One: The Evolution of MAiD in Canada and the Unmet Need for Mental Health Care

The Legislative Evolution of MAiD in Canada

MAiD refers to a situation in which a competent individual seeks and obtains medical help to end their life. In Canada, MAiD can be offered in two distinct ways. The first involves a licensed physician or nurse practitioner administering a combination of drugs at a dosage high enough to cause the death of a patient. The second involves the prescription of drugs by a licensed physician that the patient can self-administer to cause their death (Carter & Rodgerson, 2018). Since its legalization, about 31,664 Canadians have used MAiD, with a significant majority preferring to die with the help of a health practitioner. In 2020, of the 7603 individuals that died by MAiD, only 7 self-administered the prescription drugs that caused their deaths. This number decreased even further in 2021 (Health Canada, 2021; Stukalin, 2022).

Suicide legislation in Canada: A brief historical background.

The prohibition against assisted and attempted suicide was codified into law in Canada's original criminal code of 1892 (Penny, 2014). In 1972, lawmakers recognized that criminalizing suicide did little to prevent it. They agreed that it would be better addressed through health policy measures, rather than the criminal justice system. As a result, parliament repealed the crime of attempted suicide from the criminal code. However, the provision (241) criminalizing assisted suicide was maintained. It read as follows.

241. Everyone who

(a) Counsels a person to commit suicide or

(b) Aids or abets a person to commit suicide,

Whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years (Carter & Rodgerson, 2018).

In 1982, the charter of rights became operational, giving priority to individual rights and power to the Supreme Court to decide on controversial social issues (Government of Canada, 2021). This arrangement gave Canadians the platform to challenge government policies they believed to violate their individual rights, specifically the criminalization of medically assisted death. Beginning in 1992, Canadians launched a series of legal challenges against section 241(b) and related sections, which paved the way for the amendment of the criminal code in 2016 to protect physicians, nurses and pharmacists who provide a medically assisted death from prosecution. The major legal challenges that led to the amendment are briefly reviewed below.

Landmark legal challenges to 241(b)

Rodríguez.

In 1992, Sue Rodriguez, a resident of British Columbia living with Amyotrophic Lateral Sclerosis (ALS) applied to the supreme court of British Columbia, seeking the assistance of her physician to end her life at a time of her choosing (Beaudoin, 2021). Rodriguez argued that section 241(b) discriminated against her due to her disability, as it prohibited her physician from offering her the help she needed to end her life, while Canadians without disabilities were free to commit suicide without any legal implications (Melvin, 1993). Despite having the physical capability to end her life when she filed her case, Rodriguez did not want to die then. However, due to the progressive nature of ALS, she feared that there would be a time in the future when she would not want to live anymore but would not possess the physical ability to end her life herself (Pullman D. , 2020).

The British Columbia Supreme Court ruled against Ms. Rodriguez, who then filed an appeal in the British Columbia Court of Appeal that she also lost in a 2-1 decision (Melvin, 1993). In September 1993, Rodrigues took her case to the supreme court of Canada, which also ruled against her in a 5-4 decision. Although the majority of the Supreme Court judges recognized that 241 (b) violated Rodriguez's rights to liberty and security of the person, they held that prohibition against assisted suicide still upheld the principles of fundamental justice. They argued that concerns for the greater good of society and for protection of the vulnerable required continuing restrictions on assisted suicide. Therefore, the violation of sections 7, 12, and 15 of her charter rights could be justified under section 1. The minority agreed with Rodriguez, arguing that the prohibition was arbitrary and did not live up to the principles of fundamental justice (Supreme Court of Canada, 1993). Despite losing her case, Rodriquez laid a foundation for future efforts to decriminalize MAiD. The fact that the supreme court decision was a close 5-4 vote indicated potential for success in future legal challenges against 241 (b) of the criminal code.

Carter.

In 2012, Gloria Taylor, Lee Carter, Dr. William Shoichet (a Canadian physician willing to perform physician-assisted suicide if it was decriminalized) and the British Columbia Civil Liberty Association (BCCLA) challenged section 241 (b) in the Supreme Court of British Columbia. Gloria Taylor was a patient of Amyotrophic Lateral Sclerosis (ALS). Lee Carter was a daughter to Kay Carter, a Canadian woman with spinal stenosis whom Lee had accompanied to Switzerland to access a medically assisted death (Supreme Court of Canada, 2015).

The supreme court of British Columbia, presided over by Lady Justice Lynn Smith, ruled in favor of the plaintiffs, rendering section 241 (b) and related criminal code provisions that prohibit MAiD unconstitutional. She found the prohibition to be in violation of sections 7 and 15 of the charter and that the violation could not be justified under section 1 (Taylor A. , 2012). However, the federal and British Columbia governments appealed Justice Smith's decision in the British Columbia Court of appeal, which overturned her ruling. The British Columbia Court of appeal held that Justice Smith was bound by the Supreme Court's decision in Rodriguez (Canadian Council of Academies, 2018).

The plaintiffs then appealed to the Supreme Court of Canada (SCC), which unanimously upheld Justice Smith's decision, rendering 241 (b) unconstitutional. The SCC argued that although the prohibition against assisted suicide was meant to protect vulnerable Canadians from ending their own lives, it was too broad, infringing on the rights of everyone, including the non-vulnerable (Watts, 2016). The Supreme Court suspended the declaration of invalidity until June 2016 to give the government time to respond and design legislation that would guide the implementation of MAiD.

MAiD after Carter: Bill C-14.

In response to the Supreme Court decision in Carter v Canada, parliament passed Bill C-14, which set out the eligibility requirements and safeguards for the provision of MAiD. Among other requirements, one had to be suffering from a grievous, irremediable medical condition, with their natural death being reasonably foreseeable (Canadian Council of Academies, 2018). MAiD was restricted to those nearing their deaths to protect vulnerable persons from being coerced into requesting it for reasons unrelated to their illnesses. There were concerns that vulnerable people may opt for MAiD when what they truly need is improved health care services, access to palliative care, and social support (Reel, 2018).

Challenges to Bill C-14: The Truchon Decision.

Shortly after the passing of Bill C-14, it attracted multiple legal challenges, with the case of Jean Truchon et al. v. Attorney General of Canada being the most notable (Dalhousie University Health law Institute., 2021). The case involved two women, Jean Truchon and Nicole Gladu, who suffered from incurable, severely debilitating neurological conditions and had applied for MAiD (Okninski, 2021). However, they were deemed ineligible under both Quebec and federal law because their natural deaths were not reasonably foreseeable (Canada, 2021).

Truchon and Gladu argued that bill C-14 was too restrictive and violated their right to life, liberty and security of the person. On September 12th, 2019, Justice Christine Boudoin ruled in favor of the plaintiffs, declaring the requirement for a reasonably foreseeable death unconstitutional and struck it from the eligibility criteria (Okninski, 2021). Boudoin's ruling removed a significant obstacle to MAiD for those with MD-SUMC. While Bill C-14 had not explicitly excluded Canadians with MD-SUMC in its definition of "grievous and irremediable", the requirement for a foreseeable natural death made it difficult for them to qualify for MAiD (Expert Panel on MAiD and Mental Illness, 2022). Removal of this requirement made it easier for them to be eligible for MAiD.

MAiD after Truchon: Bill C7.

The federal government responded to the Truchon ruling by passing bill C-7 which, among other amendments, proposed removing requirement for a foreseeable natural death from the MAiD eligibility criteria. Bill C-7 received royal assent on March 17th, 2021, putting Canada's MAiD legislation in line with the ruling of the superior court of Quebec. Since March 2021, MAiD has been available to all Canadians who meet the eligibility criteria regardless of whether their deaths are foreseeable or not. As a safeguard for vulnerable people with mental illness, a sunset clause that "a mental illness is not an illness, disease or disability for the purposes of MAiD" was added to bill C-7. This clause, which was initially meant to expire on March 17th, 2023, will expire on 17th March 2024 (Department of Justice, 2023). The Consultations on the implementation of MAiD MD-SUMC have generated polarized debates. The main arguments from both sides are outlined below.

<u>Irremediability and Intolerability</u>

Proponents of the legalization of MAiD MDSUMC like (Dembo & Jocelyn, 2016) argue that mental illnesses can also be irremediable and intolerable. Dembo & Jocelyn cite evidence from the Sequenced Alternatives to Relieve Depression Trial (STAR*D), where 30% of the participants did not respond to anti-depressant treatment. After one year, 70% of the initially responsive patients had also relapsed. They cite another study by (Christmas, 2011) , in which only 50% of patients with refractory depression responded to invasive treatments like capsulotomy. Notably, these patients had been unresponsive to 2-4 classes of anti-depressants and two rounds of Electroconvulsive therapy. Dembo & Joselyn also present Steinhausen's review of the treatment outcomes in over 5000 anorexic patients. Steinhausen found the mortality to be significantly high. In the surviving patients, less than half recovered. A third improved, and the rest continued to live with chronic, severe, debilitating symptoms despite treatment (Steinhausen, 2002).

Sinyol and Schaffer critique Dembo & Jocelyn's argument by highlighting their use of "selective evidence". Specifically, they point out that the STAR*D study randomized patients to low-intensity pharmacological treatment with limited use of psychotherapy. They argue that achieving improvement in 70 percent of the patient group on just low-intensity pharmacotherapy is, in fact, a good outcome. Furthermore, they criticize the STAR*D study for not commenting on whether the suffering of the non-remitters was intolerable and if it could have been alleviated by additional treatments commonly used to manage depression. They also emphasize that incurability is not the same as intolerability; failure to achieve full remission from a condition does not necessarily make the symptoms unbearable (Sinyor & Schaffer, 2020).

The Center for Addiction and Mental Health (CAMH) also expressed concern about the lack of a universal standard of care that establishes a threshold for when psychiatric conditions are deemed irremediable. According to the Canadian Psychiatric Association, there is no standard of care in the country that defines how and when to classify one's mental illness as irremediable or incurable. Despite scanty evidence from a few trials, CAMH notes that knowledge about the long-term course of most mental illnesses is still very limited (CAMH, 2020; Canadian Psychiatric Association, 2021). The expert panel on MAiD also stated that clinicians require concise knowledge of the underlying pathological processes to predict disease courses accurately. Imprecise knowledge of the pathology of many mental illnesses makes it challenging for them to achieve such certainty, yet Canada’s MAiD law explicitly requires that one’s illness should be incurable and irremediable—two parameters that require certainty about disease course (Expert Panel on MAiD and Mental Illness, 2022).

Some proponents of MAiD MDSUMC argue that physicians should not rely solely on concise knowledge of the disease pathology or response to treatment to determine the irremediability of mental illnesses. They find this approach to be too narrow and non-representative of other aspects of irremediability. To them, irremediability also encompasses the degree to which the proposed treatment is acceptable to the patient. They argue that a mental illness can be irremediable if it cannot be treated by means that are acceptable to the patient, regardless of expert opinion (Bahji, 2021). For instance, a patient with severe depression that is non-responsive to first line treatment can be classified as irremediable if invasive procedures like electroconvulsive therapy or deep brain stimulation are unacceptable to them—even with available evidence of their efficacy. Similarly, a patient with severe anorexia can be classified as irremediable if repeated insertion and removal of nasogastric tubes is unacceptable to them (Dembo & Jocelyn, 2016). Some psychiatrists have expressed concern about MAiD being offered to patients who refuse potentially effective treatments. They caution that if patients have the freedom to decline evidence-based treatments in favour of MAiD, Canada could have the most permissive MAiD law (Sinyor & Schaffer, 2020).

Assessment of Capacity.

The assessment of capacity among MAiD MD SUMC applicants is another subject of debate. Opponents of MAiD MDSUMC question how assessors will ascertain that one's desire to die is a rational decision and not a symptom of their illness. They caution that capacity assessment can be challenging, particularly for patients with depression who may harbor feelings of worthlessness may not see the value in continuing to live. Apart from citing the clinical experience and consensus among MAiD assessors, proponents of the expansion have not yet satisfactorily addressed this concern. Consensus about a decision does not necessarily mean it is the right one (Expert Panel on MAiD and Mental Illness, 2022).

Stigmatization of Canadians with mental illness.

Advocates for the broadening of MAiD eligibility warn that arbitrary exclusion of those with mental illness from accessing MAiD would be stigmatizing and discriminatory. It would send a message that Canadians with mental illness cannot make important decisions about their lives and must be protected from themselves (Dying with Dignity, Canada, 2021). The opposing view is that providing MAiD to those with disabling mental illnesses is even more stigmatizing because it sends a message that a life with mental illness is not worth living. They add that Canadians with mental illness should be offered the necessary assistance to live a life as close to normal as possible instead of being presented with a stigmatizing endorsement of premature death as a solution to their suffering (Expert Panel on MAiD and Mental Illness, 2022).

Autonomy of Canadians with Mental illness.

The final concern from proponents of MAiD MD-SUMC, and the one to which this thesis responds, is that the exclusion of Canadians with mental illness from MAiD violates their right to autonomy over their bodies. They maintain that Canadians with mental illness, like everyone else, have the capacity to make autonomous MAiD requests (Dying with Dignity, Canada, 2021). The thesis challenges this argument. It argues that the autonomy of a significant fraction of Canadians with mental illness regarding MAiD decisions is not valid due to the significant barriers to mental health care that reduce the voluntariness of their requests for MAiD. It highlights the role of two barriers—long waiting times and stigma—in worsening the experience of mental suffering and cautions that MAiD-SUMC requests may be functions of the frustration of navigating the health care system and social injustices due to stigma. It also notes that the current legislation does not guarantee safe selective provision of MAID MDSUMC. This argument is presented in the subsequent chapters. In the section that follows, the thesis lays a foundation for the above argument by presenting the burden of mental illness in Canada and the prevalence of the two barriers of interest.

The burden of Mental illness in Canada.

Mental illnesses are those characterized by clinically significant alterations in thinking, mood and/or behavior with associated impairment in functioning (Public Health Agency of Canada, 2015). Mental illnesses also involve disturbance of one's cognition, emotional regulation and behavior (WHO, 2022). Mental illnesses rank highly among Canada's commonest chronic illnesses and are the primary causes of both short and long-term disability in the country (Public Health Agency of Canada, 2015). With approximately 4000 suicides annually (an average of 11 per day), mental illnesses are also among Canada's leading causes of death (Statistics Canada, 2020).

Approximately 1 in 5 Canadians experiences mental health problems in any given year (Center for Addiction and Mental Health, 2021). In 2011, an estimated 6.8 million Canadians lived with a mental illness that met the DSM-IV diagnostic criteria. This number is expected to exceed 8.9 million by 2041 (Smetanin, 2011). The most common mental disorders in Canada are mood and anxiety disorders, substance abuse, personality disorders, and psychotic disorders. Mood[1] and anxiety disorders are the most commonly diagnosed mental illnesses. An analysis of the annual mental health service use over a 14-year period (1996/97 to 2009/10) indicated that about three-quarters of Canadians who sought mental health care consulted for mood and anxiety disorders (McRae, 2016). More recently, in 2019, around 4.4 million Canadians aged 12 and older reported having a diagnosed mood or anxiety disorder, an increase from 3.7 million Canadians in 2015 (Statistics Canada, 2019).

Illicit drug abuse (or substance use) disorders, according to the 2015-2016 Canadian community health survey, is the second most common diagnosis with 3.1 million Canadians

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[1] Mood disorders is a term used to broadly describe all variants of depression and bipolar disorders.

reporting a "past-year" diagnosis. However, the lifetime prevalence[2] of illicit drugs exceeds the prevalence of mood and anxiety disorders with 9.8 million Canadians reporting illicit use of a drug or alcohol at least once in their lifetime (Bragazzi, 2021).

Personality disorders affect between 6 to 12 percent of the population. The most common personality disorders are obsessive-compulsive disorders followed by avoidant, paranoid, borderline and schizotypal personality disorders (Kellie, 2012). The prevalence of Psychotic illnesses is estimated to be around 1% (Supina, 2006). In 2004, Goeree and colleagues estimated the number of persons with schizophrenia in Canada to be 234,305 (Goeree, 2005). By 2012, the number of Canadians that had ever received a diagnosis of schizophrenia or psychosis had increased to 358,937 (Statistics Canada, 2012).

The unmet need for mental health care in Canada.

Many Canadians are unable to access the basic health care services necessary to address their mental health needs, despite mental illnesses accounting for a significant portion of the country's morbidity and mortality. According to the 2012 Canadian Community Health Survey of perceived need for mental health care, 17% of Canadians aged 15 years and older expressed a need for mental health care in the previous 12 months. Of these, only 67% received care that met their perceived needs, while 21% had their needs partially met and 12% had their needs completely unmet (Adam, 2013).

Starkes et al. also found that a significant portion of Canadians in Atlantic Canada diagnosed with major depression do not receive care consistent with treatment guidelines (Starkes,

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[2] Lifetime prevalence of illicit drug use refers to the proportion of persons surviving to a given age who have abused any drug at any time during their lives.

2005). In both studies, counselling was the need most likely to be unmet, while medication was the need most likely to be met.

Access to mental health care in Canada is hindered by a variety of obstacles. The most frequently cited obstacles include lack of access to primary care providers in some regions; primary care providers with insufficient training in mental health care delivery; lack of access to psychiatrists, especially in rural areas; stigma and lack of social support systems; unreasonably long wait times for specialist mental health care; insufficient insurance and inability to pay for counselling services (Ferlatte, 2019; Moroz, 2020). Interest is limited to two barriers: long waiting times and stigma. The two barriers are explored further below.

Barrier one: Excessively Long waiting times for publicly funded mental health care.

"When I was at my worst, I was put onto a waitlist, but because I was so sick, I ended up in the emergency room three times. Each time, I was sent home to continue waiting. The final time, I was taken to the hospital by ambulance and was so bad by this point, I was admitted."
-Victoria, Youth Advocate, Children’s Mental Health Ontario (Children's Mental Health Ontario, 2020)

"The lady on the line, she kind of laughed when I asked and said, 'you know, unfortunately, you're gonna have at least another year waiting for a psychiatrist.' At that point, I was, you know, struggling obviously a lot, and that actually sent me into a depressive episode. At that point, I had already attempted suicide as well so it was pretty urgent for me," said Hillier-Resident of St. Johns, NL (Thandi, 2021).

In 1985, parliament passed the Canada Health Act that mandated access to necessary health care for every Canadian (Harrington, 2014). This legislation tore down social-economic barriers to health care access. However, it birthed a new barrier of having to wait in line for publicly funded health care services. For the last decade, extensive waiting time for specialist services has been one of the leading policy issues affecting Canada's health care system (Liddy, 2020). Waiting times exceed what Canadians consider acceptable and are a significant barrier to receiving appropriate health care (Poulin, 2017).

Most Canadians access specialist health care through a referral system. Typically, the process starts with a visit to a general practitioner or family physician (Canadian Medical Association & College of Family Physicians of Canada, 2008). Delays are commonplace at multiple stages throughout this process. Patients often wait to see their family physician, and once a referral is made, they wait for the first specialist appointment. After the initial specialist review, another long wait may follow for specialist interventions (Jaakkimainen, 2014).

Despite spending considerably more than other Organization for Economic Co-operation and Development (OECD) countries with universal health care systems, Canada remains behind them in providing timely patient care. Currently, only 43% of Canadians can secure same-day or within 24-hour appointments with their family physician. They then wait for an average of 11.1 weeks after referral from the general practitioner for the initial specialist visit. This is followed by another 14.5 week wait for specialist intervention, bringing the total average wait time for specialist care to 25.6 weeks (Fraser Institute, 2021; Mackenzie M. a., 2021).

According to the commonwealth fund's international health policy survey of 11 developed countries with similar health systems, Canada ranks last for timely access to health care (Canadian Institute of Health Information, 2016). Approximately half of the family physicians in Canada feel that their patients wait for unreasonably long periods for specialist consultations (Naimer, 2022; Canadian Medical Association & College of Family Physicians of Canada, 2008). Only a minority of their patients (approx. 14.4%) are on the waiting list due to their own request. The majority would prefer to have their treatment administered within a week if it were possible (Mackenzie M. a., 2021). Compared with physicians in 9 other developed countries with universal health care systems, only 22% of Canadian physicians—the lowest percentage among all—reported that their patients are able to secure same or next day appointment (Schoen, 2012).

In 2006, the Canadian Psychiatric Association (CPA) set waiting time benchmarks[3] for Canadians with serious psychiatric illnesses. All emergent cases must be seen within 24 hours, non-urgent cases within 1-2 weeks, and scheduled referrals within 4 weeks (Canadian Psychiatric Association, 2006). However, available evidence suggests that waiting times for mental health care remain well above the set benchmarks and longer than those for physical illnesses (Canadian Institute for Health Information, 2017).

In Ontario, for example, considerable progress has been made toward reducing waiting times for cataract and hip replacement surgeries, with most procedures being performed within the provincial set benchmarks. However, Ontario's average waiting time for outpatient and inpatient adult mental health treatment services remains longer than the set CPA waiting time benchmark (Loebach, 2017).

Nova Scotia, the only province currently mandated to report waiting times for mental health care, has waiting times ranging from 6 to 11 days for urgent care—periods well within the CPA timeframe. However, the time for scheduled referrals is well above the benchmark, with Nova Scotians waiting for over 100 days for follow-up community mental health and addiction

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[3] Waiting time benchmark is the period that clinical evidence shows to be appropriate to wait for medical intervention.

services (Nova Scotia, 2022). The long wait for non-urgent follow-up care after the emergency mental crises undoes the good work done to avert the crises. Many people relapse into crisis mode as they wait for follow-up counselling services. This was illustrated in an Ontario study where less than two-thirds of patients discharged after admission due to depression received follow-up care within the first 30 days post-discharge. One in four patients was either re-hospitalized or readmitted to the emergency department in the first thirty days following discharge (Lin, 2011).

In Toronto, approximately two-thirds of patients referred for outpatient psychiatric care do not receive it. The median wait time for those who receive it is four months—three months above the benchmark (Lazare, 2022). These findings are similar to new data from the Canadian Institute of Health Information that 1 in 10 Canadians waited for up to 4 months for ongoing outpatient counselling services (CIHI, 2021).

In 2020, Waterloo had over 600 people waiting for mental health counselling for an average of 118 days. The list for community psychiatry was 734 people long with an average wait time of 112 days. The waitlist for a program known as Skills for Safer Living, a support group for people with recurrent suicidal thoughts had 347 names on it, with an average wait time of 334 days (Paula, 2020).

Barrier two: Stigma associated with mental illness in Canada.

Erving Goffman, in *Stigma: Notes on the Management of Spoiled Identity,* provided one of the most widely accepted descriptions of stigma. He described it as viewing a person to possess an attribute that differentiates them from others and is reduced, in their minds, from a whole, usual person to a tainted, discounted one (Goffman, 1963). Goffman's work laid ground for conceptual refinements of stigma by other scholars like Jo. C Phelan who described stigma as a social process that involves labeling, stereotyping, separation, status loss, and discrimination against a group of people that possess a distinguishing characteristic (Bruce, 2001). The distinguishing characteristic can be a disease, disability, gender, culture, or race.

Stigma associated with mental illness and discrimination against those with mental illnesses exists in many facets of Canadian life (Jagdeo, 2009). In 2012, a high 20% of Canadians with mental illnesses reported unfair treatment from their communities due to their poor mental health (Public Health Agency of Canada , 2019). In the 2014 general social survey on Canadians' safety, 10% of Canadians with mental illness reported violent victimization the 12 months prior to the survey. This was more than double the percentage of the general population without mental illness (Burczycka, 2018). In 2016, half of Canadians recovering from addiction reported experiencing stigma during their addiction periods (Canadian Centre on Substance Use and Addiction, 2017).

The Canadian Medical Association (CMA), in their 2008 report on the state of Canada’s health system revealed that only 50% of Canadians were willing to tell their colleagues that they had a family member with a mental illness, compared to 72% that would openly talk about a family member with cancer. About 61% of Canadians would not comfortably visit a family doctor or hire a lawyer they knew to live with a mental illness. A high 55% would not enter a relationship with a person with a severe mental illness, and 27% admitted they are afraid of being around someone with a severe mental illness (Spurgeon, 2008). Another study of the epidemiology of stigma against depression in Alberta's general population showed that 45.9% of Albertans held the view that depressed individuals were unpredictable. Similarly, in Ontario, attitudinal factors are believed to be among a major barrier to health care seeking among those with mental health; a significant percentage of Ontarians hold negative attitudes toward seeking help for emotional and mental problems (Jagdeo, 2009).

Canadians with mental illnesses also report employment discrimination (Stuart H. , 2006). In a 2019 survey of working Canadians, 75% of the respondents were unwilling to disclose a mental illness to their employer because they feared they would be treated differently. They were also scared of other consequences like losing their jobs. Half of the respondents felt that their ability to execute their duties would be questioned if they disclosed their mental illnesses. Three-quarters of the respondents were, however, more open to disclosing a physical illness like cancer (IPSOS, 2019).

To avoid stigma and discrimination at the workplace, Canadians go to great lengths to keep their mental illnesses a secret, including avoidance of effective mental health support programs in their workplaces. Canadians who take leave from their jobs due to mental illness find it difficult to reintegrate when they return. Sometimes, they are given "simpler tasks" and are put under stricter supervision. Those who lose their jobs due to mental illness find it hard to find new ones. With time, they begin to view themselves as unemployable and give up on looking for jobs.

Stigma in health care sector.

Anti-stigma campaigns in Canada have primarily targeted the general population, while overlooking an important section of individuals – health professionals (Schulze, 2007). Stigma among health workers is even more detrimental than that from the general public because it further isolates already marginalized patients. Stigma in health care sector appears in different forms, some intentional, others not. For instance, Knaak and Patten, in *A grounded theory model for reducing stigma in health professionals in Canada*, found Canada's mental health professionals to be pessimistic about recovery from psychiatric illnesses. This is a belief most probably adopted from their training, and not intended to stigmatize their patients. However, this pessimism about recovery was a source of stigma, feelings of hopelessness, and an obstacle to recovery for their patients (Knaak & Patten, 2016). Knaak also noted a lack of skills to deal with patients with mental illness led to anxiety among health professionals as they provided services to these patients and desire to keep them at a distance—actions experienced as stigmatizing by the patients (Knaak S. , 2017).

In a study assessing staff attitudes toward mental health consumers (who account for 10-15% of all ER visits) in Canada's Emergency Rooms (ERs), respondents felt that their complaints were always at the bottom of the triage list. On many occasions, they were told they were "not sick enough" and pushed to the end of the waiting lines, spending 8-10 hours before seeing a health worker. This bred feelings of abandonment among many participants who, after long waiting hours, give up and go home. Others reported being labelled as "psychiatric" even when they presented to the ER with non-psychiatric conditions (Clarke, 2007). One well-known event that partly involved "psychiatric labelling" is that of Brian Sinclair, a 45-year-old man found dead 34 hours after admission to the Winnipeg health sciences ER. According to a CBC report about the inquiry into his death, the health workers assumed that he was drunk and "sleeping it off"—so they did nothing. Mr. Sinclair had been referred from a community health center with a severe bladder infection to have his urinary catheter changed (CBC News, 2017).

Although Brian Sinclair's death was largely blamed on racist attitudes in health care, there were also elements of stigma against mental illness from the ER team. This was an extreme case. Diagnostic overshadowing rarely leads to death. However, it usually leads to longer waiting times as patients wait for either a psychiatry enrolled nurse, or another mental health professional to re-triage them. To avoid such treatment, some patients hide their psychiatry medical history from the health care professionals.

Chapter Summary

This chapter has provided a foundation for the arguments that develop in the chapters that follow. It begins by exploring the legislative evolution of MAiD in Canada, describing the key events and landmark cases that have shaped the country's MAiD laws. It then presents the epidemiology of mental illness, followed by a discussion of barriers to adequate mental health care. Specifically, it has examined two major barriers: extensive waiting times and stigma associated with mental illness.

Chapter Two: The Role of Stigma and Extended Wait Times in Aggravating the Intolerability of Mental Illness.

Chapter Introduction

Chapter one presented two prevalent social barriers to mental health care: extensive waiting times and the stigma associated with having a mental illness. Chapter two links these barriers to intolerable mental suffering, a core concept in assessing MAID requests in Canada. This task is accomplished by demonstrating how stigma undermines help-seeking efforts and worsens the experience of mental suffering. Additionally, chapter two explores the detrimental effects of extensive waiting on treatment outcome.

Intolerable suffering in mental illness: The role of the social environment.

In Canada, intolerable suffering is central to legally granting a patient's request for a medically assisted death (Canada, 2021). As noted in the previous chapter, the intolerability of mental suffering is at the center of MAiD MD-SUMC activism. Proponents of MAID MD-SUMC argue that suffering due to a mental illness is similar and can be every bit as grievous as that from physical illness. They demand that the two forms of suffering carry equal weight in the evaluation of MAiD requests.

It is widely recognized that suffering due to a mental illness shares many similarities with that resulting from physical illness. For example, like physical pain, mental pain can manifest as a sensory experience. Individuals with conditions like major depression can experience body aches, physical restlessness, and sleep disturbances. Anxiety can present symptoms such as migraines, muscle tension and pain, and shortness of breath. These symptoms can be equally distressing and debilitating as physical pain, leaving the affected individuals overwhelmed and helpless. Similar to physical pain, mental pain can persist for prolonged periods, significantly impacting the patient's quality of life.

While there are similarities between pain from physical and mental illness, it is imperative to acknowledge the differences between the two forms of pain, especially when assessing MAiD MDSUMC requests. Treating the two forms of pain identically would ignore important features that set them apart. One notable area in which they differ that has implications for MAiD is in the role played by the social environment in the occurrence and experience of pain or suffering.

One's social environment has been shown to play a more significant role in the development and exacerbation of mental illnesses than physical illnesses. Social stressors like isolation, poverty, unemployment, and discrimination, which may have little or no relation to one's psychiatric illness, can be a source of significant psychological pain. Such stressors sometimes cause more suffering than the psychiatric illness itself (Gaind, 2020). This is relevant for MAiD assessors because non-medical factors can be the reason behind the requests they receive.

Concern about the possibility of non-psychiatric factors driving requests for MAiD MD-SUMC is not merely theoretical; previous research conducted in jurisdictions where MD-SUMC is already legal identified non-medical causes of psychological distress as significant motivators of requests for medically assisted death. One of the studies that examined this relationship was done in Belgium by Verhofstadt (2021).

She interviewed sixteen patients with psychiatric conditions as their only underlying conditions who had requested euthanasia between 2016 and 2020. The aim of the study was to understand the motivation behind the requests for euthanasia and what could have prevented these patients from making such requests. A significant number of participants reported that their suffering would not have been perceived as intolerable without the aggravation of their situations by life events with no pathophysiological relationship to their mental illness. Some patients reported "failed health care and maltreatment" when admitted to mental health institutions, while others reported feelings of worthlessness due to self-stigma resulting from discriminatory attitudes in their societies. Notably, the study participants reported that their suffering was not perceived as intolerable at the beginning of their illnesses before internalizing these social stressors. However, over time, their suffering reached a "culmination" point beyond what they felt equipped to put up with.

How Stigma Impacts Mental Health Care Seeking Behavior.

Globally, individuals with mental illness are hesitant to seek professional assistance (Wang, 2007; Schomerus, 2009). No single factor adequately explains the low uptake of mental health care. Discussions regarding its disproportionate uptake frequently cite socio-economic factors as the major impediment. However, even in wealthy countries with universal health care and minimal financial barriers, many individuals still evade contact with mental health professionals (Thornicroft, 2010). For example, in Canada, it is estimated that sixty percent of people with ill mental health do not seek timely help (Mental Health Commission of Canada, 2022).

Stigma toward having a mental disorder and seeking help has been identified as a major obstacle that could explain the low uptake of mental health services in these societies (Dabby L, 2015; Schnyder, 2017; Villatoro, 2022). While scholars like Barney (2006) have linked stigma in general to low help-seeking intention, others have only associated particular aspects of stigma with low help-seeking intentions. For example, Boerema and Lally found public stigma[4] to influence one's help-seeking behavior more than self-stigma[5] (Boerema, 2016; Lally, 2013). Yu and Schomerus, on the other hand, found aspects of self-stigma — like internalized shame — to be more strongly associated with reluctance to seek help (Yu, 2022; Schomerus, 2009). Yap found public beliefs that mental illness is a sign of weakness and a desire for social distance to be more strongly associated with low help-seeking intentions (Yap, 2013).

Despite the variations in the more potent form of stigma, the overall trend is that stigma, regardless of the level at which it occurs, remains a critical barrier to help-seeking (Hatzenbuehler, 2013). This is because help-seeking for mental distress is an intricate and multifaceted process, reliant upon the interplay of personal, family, and cultural attitudes toward mental illness—attitudes that can either accelerate or impede one’s intention to pursue care (Rickwood, 2015 ; Calear, 2021)

Utilization of psychiatric services has an embarrassment attached to it as it is one of the strongest cues that one has ill mental health. It leads to labelling one as a "mental patient”—a label with which most people would not want to be associated. Usually, prior to being diagnosed with a mental illness, individuals already harbor certain stigmatizing beliefs about mental illness. They also often have an idea of how people with mental illnesses are devalued and discriminated against by their communities. When diagnosed, they apply these beliefs to themselves, which triggers fear of being labelled a “mentally ill” person because of the discrimination it carries with it (Yu, 2022; Barney L. J., 2006; Corrigan P. W., 2002).

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[4] Public stigma refers to negative attitudes held by the public towards those with mental illness. It is often based on misconceptions, fear, and prejudice.

[5] Self-stigma refers to negative attitudes of an individual to his/her own mental illness, usually due to internalization of the negative attitudes held by the public toward mental illness.

There is a dearth of Canadian quantitative research on mental health stigma and help-seeking intentions. Most of the available research is qualitative, exploring individual experiences of living with mental illness and dealing with stigma. So far, inquiries about these individual experiences have suggested that stigma is, indeed, associated with low help-seeking intentions among Canadians. A survey in Ontario revealed that residents were hesitant to seek professional help because of the fear of experiencing negative attitudes from others, losing their housing and jobs, and experiencing unequal treatment in other social services (Ontario Human Rights Commission, 2012).

Sudom and Zamorski (2012) conducted a study on the impact of stigma on mental health care utilization in Canadian armed personnel. The authors found that negative attitudes toward care were significantly linked to a reduced inclination towards seeking help. Similarly, Pietrzak and colleagues investigated the relationship between perceived stigma and mental health care utilization among American veterans. Their study revealed that stigma and negative attitudes — especially towards psychotherapy, were linked to a reduced likelihood of utilization of mental health counselling and psychiatric medication (Pietrzak, 2009). Further, Mackenzie et al., examined the relationship between age and mental help-seeking barriers in Canada. They found that older Canadians had less of stigma and more positive help-seeking attitudes toward help seeking than their younger counterparts (Mackenzie C. S., 2019).

While a significant number of Canadians have negative attitudes towards seeking help, there are a few that would like to seek help. These are however deterred by the anticipation of stigmatizing attitudes from health professionals. In the 2012 *Minds that matter* report by the Ontario Human right Commission, Canadians' experiences with mental health professionals emerged as a major theme. Ontario residents reported feeling devalued by mental health workers, with some encountering a dismissive attitude from health workers; when some tried to question a diagnosis they felt was inaccurate, they reported being met with a “smug smile and a dismissal”. Others reported that their complaints and feelings were not given due consideration because they did not conform to the psychiatrist’s “rule book”, resulting into them feeling unheard and unseen (Ontario Human Rights Commission, 2012).

Stigmatizing attitudes among health professionals become even more problematic when people with mental illnesses need care for physical illnesses. Despite individuals with serious mental illnesses being disproportionately affected by physical illness (Kaufman, 2012), with a reduced life expectancy compared to the general population (Viron & Stern, 2010), they, still receive inferior physical health care (Thornicroft, 2010; Druss, 2001). Kisely and colleagues found Canadians with ischemic heart disease and a history of schizophrenia or related psychosis less likely to receive care consistent with treatment guidelines despite having an increased 1- year mortality rate (Kisely S. C., 2009). Such discrepancies keep Canadians with mental illness away from seeking help, even when their attitudes toward utilization of care is positive.

There are studies outside Canada that have explored the influence of stigma on help seeking behavior more vividly. One notable study by (Barney & Griffiths, 2009) examined the nature of stigmatizing beliefs about depression and their influence on help-seeking. In this study, participants expressed apprehension about the consequences of being identified as someone with a mental illness. The anticipation of being treated differently by their communities thwarted their willingness to seek help. Some of the survey responses by the participants are presented below:

Participant A: *"For many years, I put off getting help, mainly because my husband didn't want me to. He thought that it put some stigma onto him if he had a wife who had depression and who needed psychiatric help."*

Participant B: *"You think they'll never look at me the way they used to, they'll always look at me as though I've got problems ... you don't want them to have these bad opinions of you."*

Participant C*: "You wear it from the day you are diagnosed with a 'mental illness', and that's the stigma. Depression on its own, well, it's the new fashion to say you've got depression, but you say you've got a mental illness – they look at you and they expect you to be a dribbling idiot."*

Participant D: *"I'm finding it very difficult to go back to see the same psychiatrist again. On the first visit he had a pretty condescending attitude – without saying as much he kind of indicated 'you've got to pull yourself together."*

Participant E: *"You're treated as if you've done something or something's happened for you to get this... and this is from trained psychiatrists specialising in mental illness."*

As depicted by the responses above, stigma exacerbates the challenge of managing mental illness by impeding the sufferer's efforts to seek appropriate care, which in some instances leads to their illness becoming resistant to treatment. This eventually leads to experiencing the mental illness as intolerable and irremediable.

The argument that this hypothesis offers sound justification for exclusion of Canadians with mental illness from MAiD is vulnerable to one rebuttal: stigma associated with mental illness is not specific to Canada; it is prevalent in other countries where MAiD MD-SUMC is legal. It, therefore, on its own, should not be deemed sufficient justification for excluding Canadians with mental illness from participating in MAiD.

While the prevalence of stigma is universal, there are variations in how it is experienced within and between communities (Pescosolido, 2013). These disparities stem from socio-cultural differences that shape distinct perceptions and experiences of mental illness and the stigma associated with it (Sontag-Padilla, 2016). It is the interaction between mental illness and community-specific aspects like race, gender, and religion that differentiates the experience of stigma. There are also nuances in its effect on help-seeking behavior depending on one's life experiences and country-specific factors like ease of access to mental health care.

The experience of stigma and its impact on Canadians' help-seeking behavior differs from that of residents of other pro-MAiD MD-SUMC jurisdictions for two main reasons. Firstly, Canada's population is notably more diverse, with a considerably larger proportion of residents belonging to minority groups. For instance, Canada's most predominant minority group—Asian Canadians—accounts for about 15 percent (approx. 5 million) of the population. In some cities, like Vancouver, as high as 43% of residents identify as Asian (Livingston, 2018). The residency status of many of these individuals allows them to be eligible for health services funded by the federal government, provinces or territories. They would thus be eligible for MAiD if they satisfy other criteria.

Due to their large number, their cultures are more established and thus more influential on their attitudes toward mental illness. Some of these cultures are still less accepting of living with a mental illness. For example, according to one Canadian study, many Asian men in the country still strongly value maintaining a "stable" social image. They view mental illness as a threat to their “stability and manhood," which, to them, represents toughness and total independence (Livingston, 2018). Another study by Tie & Konnert found older Chinese immigrants in Canada to be more reluctant to seek help than their Canadian-born counterparts. These attitudes were related to their cultural beliefs (Tieu & Konnert, 2014). In contrast, other jurisdictions like Belgium, foreign born residents — predominantly immigrants from North Africa and Asia — constitute less than a tenth of the country’s population (Lamberts, 2022). Their cultures are thus not as well established as they would be if they constituted a larger proportion. Consequently, they are more easily influenced by the predominant European culture, which, is more accepting of mental illness and open to seeking help when having ill mental health. Therefore, a young Canadian of Asian descent living in a town where almost half the residents identify strongly with Asian culture will experience stigma differently than a young Belgian of Asian descent living in a town where only a few people identify strongly with Asian culture.

The second reason why the experience of stigma in Canada differs from that in other jurisdictions is that stigma in Canada is compounded by other bottlenecks in the mental health care system that impedes easy access to care (Henderson, 2013). Canadians, on top of being scared of their peers knowing about their mental illness, cannot easily access non-physician psychological therapies as they are not funded by the public purse. In Belgium and Netherlands, these services are part of publicly funded health care.

The Influence of Stigma on the Experience of Mental Distress.

Stigma aggravates mental suffering in multiple ways (Hamilton, 2016), one of which is by promoting practices that increase existential suffering among those already suffering due to a mental illness. The existential suffering then worsens the symptoms of one’s mental illness to clinically significant proportions that they are experienced as severely incapacitating, intolerable and irremediable leading to suicide or requests for physician-assisted suicide (Amonoo, 2020). Some practices in Canada that are fueled by stigma toward mental illness include exclusion from social and economic integration (Canadian Mental Health Association, 2022).

Social exclusion, discrimination, and lack of access to economic resources are key factors hindering the full participation of Canadians with mental illnesses in their communities. This exclusion prevents them from obtaining adequate housing, health care and making meaningful relationships—activities that are essential for attaining important social milestones that are protective against new mental illness and also lessen the psychological pain due to pre-existing mental illnesses (Corrigan P. , 2004).

The Link Between Extensive Wait Times and Poor Treatment Outcomes.

The relationship between early initiation of appropriate treatment and good outcomes is well documented in medicine. Like physical illnesses, early detection of mental disorders and prompt commencement of therapy reduce the burden of illnesses and raise the prospects of improved short and long-term outcomes (Hernan, 2010). On the other hand, delayed treatment and long durations of inadequate treatment, contribute to the development of complications that can be intractable (Edbrooke-Childs, 2020).

Conversations about the impact of delayed diagnosis and treatment on psychiatric illnesses began in the early 1990s with scholars like RJ Wyatt, who explored the role of neuroleptic drugs (also known as antipsychotic drugs) in changing the course of schizophrenia. He found early intervention to improve the likelihood of an improved long-term course (Wyatt, 1991; 1998). Wyatt's early work on schizophrenia laid a foundation for further research that also established the critical role of the early months in the evolution of mental disorders. Studies have suggested that the duration of untreated illness strongly predicts an individual's response to pharmacological and psychological treatment. An individual's response to treatment is inversely proportional to the length of untreated–or inadequately treated symptoms (Kisely S. S., 2006).

Numerous researchers have investigated the impact of delayed intervention on various mental illnesses. Haas et al. associated delayed initiation of antipsychotic treatment with a more severe and persistent symptomatology of psychosis and significantly elevated risk for relapse (Haas, 1998). Addington described the first episode of psychosis as a critical therapeutic opportunity, with patients who receive appropriate treatment in this therapeutic window achieving positive outcomes (Addington, 2002).

Similarly, Bukh et al. studied the effect of prolonged duration of poorly treated depression on the response to antidepressant treatment. They found that the remission rate significantly decreased among patients with six or more months of untreated major depression. The odds of remission were halved when appropriate antidepressant treatment was initiated more than six months after the onset of the first episode (Bukh, 2013). Altamura et al. also linked long duration of untreated depression to a higher number of recurrences and a higher likelihood of comorbidities like substance abuse. Both lower the efficacy of treatment (Altamura, 2007).

Conus associated delayed initiation of the appropriate treatment for bipolar affective disorder to a higher number of manic and depressive episodes and an increased rate of relapse. This is because the effect of lithium carbonate—the drug of choice for treating Bipolar Affective Disorder— decreases with increasing delays in its initiation (Conus, 2014). Further, increased frequency of manic-depressive episodes (which happens with delayed treatment) is associated with decreased response to olanzapine, another drug widely used to reduce the occurrence of manic episodes (Berk, 2011).

Multiple hypotheses have been forwarded to explain the relationship between delayed appropriate treatment and suboptimal outcomes. One school of thought is that neurotoxic changes that alter neuronal function occur during periods of untreated illness. As the illness episodes recur, the changes become more permanent (Conus, 2014). Another hypothesis is that there is progressive structural brain damage caused by stress hormones released during episodes of mental breakdown (Wood, 2009). Poor response to treatment is also attributed to the progression of single disorders to complex comorbid disorders (Kessler, 1993); for example, major depression can be complicated by substance abuse as the patient tries to cope with untreated symptoms.

According to the college of family physicians of Canada, the Canadian psychological association and Canadian psychiatric association (2020), many Canadians seek psychiatric care from their family physicians, many of whom lack the time, necessary training and resources to adequately manage severe mental illnesses. The implication for Canadians with severe mental illnesses is that they usually need referral to a mental health specialist for proper management. However, after a referral from their family physicians, they wait for extended periods for specialist appointments with inadequately treated or untreated symptoms. The early key months for effective intervention are thus missed, setting them up for poor treatment outcomes even when the specialists finally start the appropriate treatments.

The Impact of Extensive Waiting Times on Help Seeking.

Long waiting times are a widely recognised barrier to help-seeking (Edbrooke-Childs, 2020; Redko, 2006). Extensive waiting has been identified as a hindrance to both treatment initiation, as well as a motivation for premature discontinuation of ongoing treatment (Foreman & Hanna, 2000). It is also associated with decreased appointment attendance, as highlighted by Carter and colleagues in a study of the factors associated with dropping out of cognitive behavioral therapy for patients with eating disorders. They found that time spent waiting for initial specialist assessment was a significant predictor of adherence. The majority of patients that completed treatment had waited for less than five months, while most of those that dropped out had waited for 6 to 12 months (Carter O. P., 2012). Westin et al. came to a similar conclusion after examining the effect of waiting time on the engagement of 2,054 youths with evidence-based treatments. Their results indicated that patients are more likely to avoid initial contact with mental health professionals if they face prolonged waiting times. They are also more likely not to engage with subsequent appointments after missing the initial appointment (Westin, 2014) .

Another study, analyzing 5900 consecutive patients referred to the Johns Hopkins Bayview Medical center over five years found a strong linear relationship between delays in appointment scheduling and no-shows. In particular, increased waiting time for an initial appointment adversely affected the rate of kept appointments (Gallucci, 2005). McCann & Lubman also identified long waiting times among the top two barriers to attending initial appointments in Australian youth with depression (McCann & Lubman, 2012).

Williams and Conversano, evaluated efforts by a large urban community health center that serves over 30,000 people to eliminate outpatient waiting lists for psychiatric services for American adults with severe mental illness. Using various strategies, the wait time was reduced from 13 to 0 days. This was followed by a drop in the no-show rate from 52 to 18 percent, a strong indication that waiting times have an independent impact on help-seeking behavior (Williams & Conversano, 2008).

People with mental illness usually seek help during spells of heightened symptom severity—spells during which they may also face other barriers such as stigma, inadequate financial resources, and long distances from psychiatric services. These obstacles can result into ambivalence about seeking care (McCann & Lubman, 2012). The crucial periods of increased motivation to seek help amidst other barriers are short. When appointments are delayed, the opportunity to engage with them when their willingness is high is missed. Unfortunately, many do not regain the motivation to seek help until their illnesses are well advanced, more difficult to manage, and could pass as intolerable and irremediable to the MAiD assessor.

Chapter Summary

Chapter two has sought to establish a link between mental health stigma, long waiting times and the intolerability of mental illness. This link has been demonstrated by highlighting how each barrier exacerbates mental suffering and reduces help-seeking intentions. Mental illness stigma worsens mental suffering by perpetuating practices that worsen existential suffering in those already experiencing mental suffering. Furthermore, it diminishes motivation to seek help by instilling fear of possible discrimination that might result from being labelled as mentally ill.

Extended waiting periods for appointments reduce the utility gain from treatment since illnesses progress to stages that are difficult to manage. They are also associated with poor attendance of appointments, especially among patients ambivalent about seeking help. Although stigma and long waiting times on their own do not make mental illness intolerable, they substantially contribute to the experience of mental disorders as intolerable. The influence of these barriers on Canadian MAiD MD-SUMC requests should thus not be taken lightly.

Chapter Three: The Centrality of Socio-Relational Autonomy in Canadians' Decisions to request MAiD MD-SUMC.

Chapter Introduction

Chapters one and two highlighted the barriers to mental health care in Canada and linked them to intolerable mental suffering. The overarching aim of chapter three is to examine the influence of these barriers on the autonomy of Canadians with MD-SUMC who choose medically assisted deaths. The chapter does not examine the psychological competence of Canadians with mental illness, but rather the impact of these barriers on the voluntariness of their MAiD decisions. The argument is presented using the social relational notion of autonomy and is laid out in two broad sections. The first section presents the individual autonomy-based justification for MAiD-MDSUMC, as well as the contrasting notion of socio-relational autonomy. The second section offers an ethical analysis of MAiD MD-SUMC through the socio-relational autonomy lens.

The autonomy-based justification for MAiD MD-SUMC.

Proponents of the extension of MAiD to Canadians with MD-SUMC charge that their exclusion is an unjustified infringement on their right to personal autonomy. The shade of personal autonomy they seek to protect is derived from Immanuel Kant's and John Stuart Mill's principles of autonomy and individualism, respectively (Johnson, 2015; Christman J. , 2020). This notion of personal autonomy focuses on persons as independent, self-interested agents capable of making their own decisions (Donchin & Scully, 2015).

Under this dominant understanding of autonomy, one’s ability to live as a self-governing agent depends on two major factors: psychological competence and freedom from coercion. Emphasis is placed on these procedural conditions; if they are met, the decision is regarded as autonomous regardless of its value. We are required to respect such decisions even if we disagree with them (Wilson, 2007; Dove, 2017). An example is that of a patient making a medical decision after receiving adequate information from their surgeon. For this patient to be regarded as autonomous, they must have the psychological capacity and freedom from direct coercion by the physician, family or friends.

According to this understanding of autonomy, the decisions to seek MAiD by Canadians with MD-SUMC are autonomous and respect-worthy if they are made with a competent mind and are free from interference from external agents. This notion of autonomy, which going forward, I refer to as hyper-individualist, focuses on Canadians' value-neutral decisions and the immediate coercion-free conditions under which they occur.

Having a mental illness is known to interfere with the internal capacities necessary for autonomy and thus constrain one's ability to behave autonomously. There is scientific evidence to support this claim (Bergamin, 2022; Christman J. , 2009). It is indeed true that there are times when people with mental illnesses are unable to fulfill the internal requirements for autonomy. However, the psychological competence of Canadians with mental illness is not the focus of discussion in this chapter. I have little concern about them accessing medical assistance in dying during break-down episodes when it is clear they do not fulfill the competence requirements. I assume that no provider would ethically approve a MAiD request of an individual clearly crumbling under the weight of a psychotic or major depressive episode.

Despite being at risk of having their competence compromised by an underlying illness, people with mental illness are not always acting under the influence of illness. Many mental illnesses are known to cause distress episodically. It is not uncommon for an individual known to live with schizophrenia, psychosis, or depression to be free from severe autonomy-diminishing symptoms for long periods. In fact, there is empirical evidence of individuals with psychiatric illness, in particular, clinical depression, passing as competent on routine competence assessment tests (Pugh, 2020). It would be in such periods where they are believed to satisfy the hyper-individualist requirements for autonomy that MAiD requests from them might be considered. This period is what is of interest to this chapter.

The Socio-relational notion of personal autonomy.

Feminist philosophers have criticized the radical independence that is at the center of the hyper-individualist notion of autonomy. They have argued that humans are socially embedded creatures and that the atomist, totally independent agent does not exist outside of theory (Mackenzie C. , 2021). They note that the hyper-individualist notion of autonomy ignores the impact of relational personhood on individual autonomy—especially that of socially subordinate groups (Oshana, 2006).

Relational theorists maintain that autonomy is not exercised in a void but within the complex web of social-relational factors (McLeod & Sherwin, 2000). Our decisions are fostered within the dynamics of our relationships and certain socio-political environments that can either enhance or constrain our autonomy (Lister, 2003). Consider, for example, the illustrative scenario mentioned above of a patient making a medical decision. Factors like socially constructed gender norms, power relationships, and low socio-economic status can limit individual's access to information and could lower their self-confidence to challenge physicians when they do not agree with the proposed treatment (Shih, 2018).

Advocates of 'relational autonomy' do not completely disregard the hyper-individualist notion of autonomy; they concede, after all, that there is no relationality without individualism. However, they deem hyper-individualist requirements, on their own, to be insufficient to exercise autonomy fully. They find it concerning to regard one's decision as their own if all it is free from is direct coercion at the time it is made. They condemn the hyper-individualist view of autonomy for relegating an optimal social environment to a mere add-on to one's psychological competencies in the exercise of autonomy (Dove, 2017). Socio-relational factors do not merely enhance autonomy, they are critical for its attainment (Gómez-Vírseda C. M., 2020).

Advocates of this position propose a reconceptualization of the principle of respect for autonomy from a relational standpoint (Gómez-Vírseda, Maeseneer, & Gastmans, 2019). This reconceptualization has been identified by various names; some refer to it as relational autonomy (Mackenzie C. , 2013) while others call it socio-relational autonomy (Oshana, 2006). Both are umbrella terms for the various views of autonomous agents as socially embedded, with their identities nurtured within the context of their relationships and the complex web of social, economic and political determinants (Christman J. , 2004). For purposes of consistency, I refer to it as socio-relational autonomy.

What follows is a countercharge against the claim that MAiD requests from Canadians with MD-SUMC are an expression of autonomy because they satisfy the hyper-individualist procedural requirements. I argue that the hyper-individualist view is impoverished in its treatment of Canadians with MD-SUMC as isolated individuals making isolated MAiD decisions amid significant barriers to timely health care. Treating these decisions as fully autonomous would be looking at autonomy as a characteristic of decisions, rather than a characteristic of persons and their lived experiences (Gómez-Vírseda C. M., 2020). The hyper-individualist view also ignores the fact that autonomy is exercised in an interactive, continuously evolving process—not in isolated moments of choice (Killackey, 2020). I draw upon the socio-relational notion of autonomy to advance this agenda.

As noted earlier, socio-relational autonomy is a multipronged concept with many views informing this notion of autonomy. Interest is limited to the view that is relevant to the argument at hand. This is the view that socio-relational conditions are not simply background conditions for autonomy but rather, key requirements for its full exercise (Baumann, 2008; Lewis, 2019; Nedelsky, 2011). I argue that the socio-relational environment surrounding Canadians with MD-SUMC will have a coercive effect on a significant portion of MAiD MD-SUMC requests. For clarity, I begin by explaining what is meant by coercion in the socio-relational context.

Coercion in the socio-relational context.

The term coercion is subject to a variety of interpretations in relation to autonomy. Therefore, it is key to clarify the understanding of coercion employed in this discussion. In general, the term coercion is used to describe the use of force to persuade someone to do something they are unwilling to do (Cambridge Dictionary, n.d.). In bioethics, coercion describes any force—external or internal—that exerts undue influence on an agent, forcing them to make a decision that is not representative of their authentic desire.

As regards the hyper-individualist notion of autonomy, coercion is prominently understood in two ways; the first involves the use of proposals or directives that force an agent to accept certain medical treatments or procedures against their will (Blumenthal-Barby, 2012). In the day-to-day patient-physician interaction, a proposal might be a threat if it indicates an intention to make the agent worse off or to allow their suffering to continue if they do not comply with the physician's proposal. For example, it would count as threat-based coercion if a physician-researcher indicates to a patient that they will not receive proper treatment if they do not enroll in an experimental drug clinical trial. This type of coercion might also come from family members who could, for instance, threaten to abandon a patient if they do not choose a particular treatment option. The second understanding involves using conditional offers that are "too good to refuse" in exchange for an individual's consent to undergo certain medical treatments/procedures (Scott, 2021). Examples might include huge financial rewards, luxury trips, or expensive gifts.

The understanding of coercion as applied in hyper-individualist autonomy is limited and fails to consider the often subtle yet powerful influence of social, economic, and political factors in shaping the expression of autonomy. I use the term coercion to refer to the controlling influence of external social-relational forces, distinct from threats and unreasonable offers, that affect the reflective elements of decision-making. Unlike threats and offers, coercion as used in this chapter does not necessarily require intentional or direct exertion by the controlling party. It can result from unintentional acts of omission (like inadequate health care) that constrain decision making by narrowing available options.

This notion of coercion is well illustrated in prisoners' participation in clinical research. Despite being psychologically competent to make autonomous decisions, their social position in the prison environment renders them vulnerable and diminishes their ability to exercise their autonomy fully. Even when free from direct coercion from prison authorities, their consent to clinical research is not taken at face value, as it might be fueled by an attempt to access what they think could be health care superior to what they usually have. The voluntariness of their participation is always under the REB microscope for one major reason: their socio-relational environment.

Ethical analysis.

The Centrality of Socio-Relational autonomy in Canadians' decision to choose MAiD MD-SUMC.

The autonomy-based argument that MAiD MD-SUMC is justified as long as it is autonomously requested has been a basis for its legalization in multiple jurisdictions. While this argument might hold in some countries, it currently cannot hold in Canada because of the barriers to mental health care that significantly contribute to the intolerability of mental suffering. By worsening the experience of mental illness, these barriers can coerce many Canadians to request MAiD MD-SUMC. To demonstrate the coercive, autonomy-limiting effect of these barriers, two real-life Canadian case studies are presented.

Denise.

In August 2022, a woman in Toronto who went by the alias of Denise died by MAiD. In the letters she left behind, Denise indicated that her suffering from her underlying condition had been worsened by her failure to find appropriate, affordable housing. Denise had been diagnosed with Multiple Chemical Sensitivities (MCS) –a condition in which one suffers severe anaphylaxis when they come in contact with common household chemical substances like cigarette smoke, air fresheners, laundry chemicals, etc. By her own admission, Denise was driven to despair by a lack of affordable, suitable housing with clean air. Her only source of income was the Ontario disability program, where she got approx. $1200 per month. She thus could not afford housing in Toronto. After contacting over ten agencies in the city over six months seeking assistance to find affordable housing, she could not get any meaningful assistance.

In February 2022, Denise decided to pursue MAiD after her search for housing failed. She did not, however, cite failure to find housing as her reason for seeking MAiD. She fronted intolerable suffering due to MCS. In May 2022, after having her request conditionally approved (pending the 90 days for track 2 requests), Denise put her request on hold. This was after well-wishers donated money she used to secure temporary safe housing. In an interview with The Independent, Denise noted that the support she had received had "stabilized" her life. She was living in a temporary home where she was not struggling with anaphylaxis anymore, and her suffering had significantly decreased. She noted, "I am no longer focusing on survival. Mentally, I am clearer to put things in place to put a more livable life" (The Independent, 2022).

In August 2022, Denise went ahead with her MAiD request after leaving her temporary housing, becoming the first person to access MAiD due to multiple chemical sensitivities. She, however, left behind letters detailing her desperate search for housing, begging local, provincial and federal officials for assistance that never came. She asked one of her supporters to share these letters only after her death, as she feared that her MAiD request would be delayed if they came to light. Before her death, in a phone interview with CTV, a Canadian News television channel, she confessed that "I have applied to MAiD essentially… because of abject poverty (Favarro, 2022)*".*

Amir.

Amir Farsoud, a 54-year-old Ontario resident, applied for MAiD in 2022 due to the fear of losing his housing. Amir suffered from severe chronic lower back pain from an injury he sustained in his younger years. The back pain is so severe that it keeps him awake for many days in a row. He is also on antidepressant and antianxiety medication. He admitted that he will, at some point in his life, consider MAiD as his condition is expected to get worse. However, he noted *that his pain had not yet progressed to the level that would induce him to apply for MAiD. He attributed his premature MAiD application to the extreme fear of homelessness given his current health status. In an interview with city News, he revealed that he is more afraid of being homeless than dying—so he chose the latter. He said that, "I don't want to die but I don't want to be homeless more than I don't want to die. I know, in my present health condition, I wouldn't survive it (being homeless) anyway. It wouldn't at all be dignified waiting, so if these are my two options, it's pretty much a no-brainer." At the time of this interview, his MAiD request had been approved by one physician* (Mulligan & Bond, 2022)**.**

The cases above are not of individuals with mental illnesses as their sole underlying conditions. However, they are relevant to this argument for three reasons; first, Denise and Amir were all mentally competent. Secondly, none of them was directly coerced by anyone to request MAiD. Finally, none of them was terminally ill. The two case studies are of people in reasonably similar positions as Canadians who would be eligible for MAiD MD-SUMC. These scenarios share and bring to the fore one key theme: decisions to request assisted death are seldom isolated medical decisions solely due to the suffering caused by the underlying medical condition.

From Denise's media interviews, and her proactive efforts to find appropriate housing, it is clear that her priority was to stay alive. However, her experience of multiple chemical sensitivity markedly worsened without appropriate housing, and her will to live diminished. Amir also makes it clear that, currently, he prefers to stay alive. He is, however, being forced by the fear of homelessness to end his life prematurely. In both cases, non-clinical aspects substantially contribute to the intolerability of suffering and feelings of hopelessness— two factors that are critical in shaping the experience of one's underlying medical condition.

An assumption that Denise’s and Amir’s decisions to seek assisted deaths were fully autonomous because they were made with intact psychology and in a procedurally independent manner would be flawed. Such an understanding would be reducing autonomy to merely possessing ability to understand information, analyze it, and come to a decision (Tonelli, 2010). Yet, as many patients have testified, decisions at the end of life are powered by many external factors (Gómez-Vírseda C. M., 2020, pp. 2-3). To consider the decisions in the case studies above fully autonomous, one has to neglect the inconspicuous yet potent influence of the external environment in which these decisions were taken. This coercive influence is depicted by the temporary suspension of Denise's request for MAiD when she receives social support from her community.

It could be argued that requiring one's environment to be optimal and supportive of autonomy as a condition to respect their decisions is unrealistic because the climate in which day-to-day decisions are made is not — and can never be — fully optimal. Nevertheless, decisions still have to be made and, if autonomous, respected. It is true, in part, that requiring one’s environment to be free from deprivations as a condition to respect their decisions would excessively infringe on the exercise of their autonomy. In most cases, despite presence of certain deprivations that might shape one’s life experience, their decisions ought to be respected. There are, however, some exceptions to this rule. Some deprivations are so important that they are incompatible with full autonomy. Such deprivations are so major that they contribute significantly to one’s suffering, and their absence significantly lessens this suffering. It would be ethically perverse to render decisions motivated by intolerable suffering fully autonomous in the presence of such deprivations.

The autonomy-diminishing effect of inadequate mental health care.

In Personal *Autonomy in Society*, Marina Oshana offers a convincing account of personal autonomy, arguing that it is rooted in the idea that social relations matter profoundly. Specifically, she argues that certain conditions must hold for one's choices to be regarded fully autonomous. She describes six conditions: epistemic competence; rationality; procedural independence; self-respect; control; and access to a range of relevant options. She notes that presence of these conditions provides an individual with greater ability to make choices that are not influenced by external factors, ensuring that an agent is sufficiently autonomous. (Parvin, 2007; Oshana, 2006). Oshana acknowledges that her position might not sit well with liberal political theorists who believe that free choice is more important than where the choice comes from. She admits that requiring certain socio-relational conditions for one to exercise autonomy fully would require governments to actively work toward creating such environments. Liberals view this as an overreaching intervention in people's lives by a government and hold that a government should be impartial and have no particular vision of the "good life" (Parvin, 2007).

Oshana's theory does not require that all conditions are satisfied at once for an individual's choice to be regarded autonomous. Different decisions and different individuals may require different conditions to be met for them to be regarded autonomous; for example, simple decisions that are held to a lower standard of autonomy may only need to satisfy a few of Oshana's conditions. Riskier, more permanent decisions—like death—that are held to a higher standard of autonomy may need to satisfy most, or all the conditions. Additionally, vulnerable people may require more conditions to be met than non-vulnerable people for their decisions to be regarded free from coercion by external factors. Oshana's argument is relevant to the current discourse about autonomy and MAiD MD-SUMC in many aspects, one of them being that inadequate mental health care restricts access to a suitable range of alternatives to MAiD, thereby undermining the autonomy of Canadians with mental illness regarding their decisions to seek MAiD.

The argument put forth by advocates of hyper-individualistic autonomy that MAiD decisions of Canadians with MDSUMC are fully autonomous is flawed because it isolates MAiD choices from the broader health care environment in which they are made. This view ignores the limited control Canadians have over their pathways within the healthcare system. Ho (2008) notes that several factors beyond Canadians' control determine their navigation of the health care system; for example, logistical factors may determine the ease of access to specialized health care, dictating what options are available to an individual. As chapter two illustrates, Canada's mental health care is not as well funded as other forms of health care. The limited logistics narrow the range of accessible therapies and mental health specialists. Navigation of the health care system is thus more frustrating for Canadians with mental illness than those with physical illness—frustration that worsens their mental suffering. It is thus unreasonable to separate MAiD MDSUMC decisions that would rest on the experience of mental suffering from the factors that shape this experience.

The relationship between the range of available options and ability to exercise autonomy must be taken into account when evaluating individual autonomy in the context of MAiD MD-SUMC. This is because, unlike their counterparts with the so-called physical illnesses, Canadians with MDSUMC are not presented with reasonable alternatives to MAiD by the health system. For their MAiD requests to be considered fully autonomous, Canadians with MD-SUMC must be provided with options to MAiD in a robust manner that would promote critical reflection (Collins & Leier, 2017). Without options such as easily accessible, comprehensive, robust end-of-life care and palliative care, the voluntariness of MAiD MD-SUMC decisions will remain under scrutiny due to the constraints on voluntariness resulting from lack of relevant alternatives (Council of Canadian Academies, 2018).

One may argue against Oshana’s requirement for access to a relevant range of alternatives as a prerequisite for the full exercise of autonomy, suggesting that limiting one's choices only constrains their autonomy to the extent that this restriction is acknowledged by the agent. If an agent comes to terms with the fact that their options have been limited, then his choice from the available, limited options counts as autonomous. In response, consent to the loss of freedom and consideration of one’s constraining surroundings as “normal” does not lessen the damaging effects of these surroundings on an individual’s autonomy. In fact, individuals may settle for certain decisions that are not reflective of their authentic desires due to internalization of the autonomy-diminishing characteristics in their environment. Accepting social injustices as normal does not make them morally acceptable. Some may also argue that an individual can autonomously make choices from any set of options that escape systemic interference—regardless of how limited they may be. As long as an agent is unaware of this limitation, they make their decision autonomously. This view is also flawed because one cannot be regarded as sufficiently autonomous when the system in which they make decisions deliberately pre-empts their options. While they remain autonomous in other facets of life, they lose this autonomy when making decisions in the sector of their lives to which the obstructed choices are relevant.

The Impact of Stigma on Autonomy.

Mackenzie Catriona's view of relational autonomy as a status concept is key to understanding how stigma and discrimination diminish one's autonomy. She notes that, to be fully self-determining, one needs to be recognized systemically as having the social status of an autonomous agent. Such recognition is absent in relationships characterized by stigma and discrimination. Stigma leads to marginalization and limits access to resources and opportunities necessary for self-determination (Mackenzie C. , 2021). Canadians with mental illness face systemic barriers to health care, proper housing, and other resources that are necessary for exercising autonomy. As noted in the case studies, these barriers undermine individual's ability to make choices consistent with their authentic values and interests.

Stigma and the resulting systemic non-recognition of Canadians with mental illnesses also impacts their sense of self and ability to exercise agency. In *Autonomy and Vulnerability Entwined,* Anderson argues that other people's attitudes can significantly influence our autonomous agency by enhancing or undermining our sense of self. He maintains that our autonomy is dependent on relations of respectful mutual recognition and that our need for such recognition makes us vulnerable to the changing attitudes of those surrounding us (Anderson, 2014). Anderson and Mackenzie both agree that when subjected to degrading treatment, or are denied respectful recognition, individuals find it difficult to see themselves as autonomous agents with ability to make meaningful decisions. Relationships characterized by stigma, discrimination and disrespect eat away at one's self-trust, self-respect and self-esteem—aspects that Anderson says nurture autonomous agency.

Exclusion of Canadians with mental illness from autonomy enhancing activities also increases their vulnerability, keeping them dependent on the good will of others. Such dependence leaves them with little control over how they experience life. Oshana (2006) cites control over one's life as one of the essential requirements for full exercise of agency. She argues that personal autonomy requires control of a vigorous kind; for one to be fully autonomous, they must have the power to determine how they shall live. Coercive impediments like exclusion from autonomy enhancing activities and respectful relationships reduce this power, leaving individuals vulnerable to changing social, economic and political climates. Anderson (2014) shares Oshana's view that one's degree of autonomy is significantly determined by how strongly one can retain control of their life in the face of changing social circumstances.

Linking vulnerability to diminished autonomy could unsettle proponents of the expansion of MAiD, who might argue that being vulnerable does not necessarily constrain one's autonomy. Admittedly, vulnerability does not always diminish autonomy. There are certain respects in which vulnerability is, in fact, autonomy-promoting. As argued previously, autonomous agency depends significantly on interpersonal relationships—relationships that are initiated and sustained by our vulnerability to each other. This form of vulnerability is inherent to all of us as humans and allows us to participate in autonomy-enhancing activities (Mao, 2020). Rogers refers to this as universal vulnerability (Rogers, 2014).

Another respect in which vulnerability is not autonomy-diminishing is when reasonable measures have been taken to mitigate the disadvantages it causes. Vulnerability about which nothing more can be done does not necessarily limit one's autonomy because it does not constrict one's range of relevant alternative choices—it only presents a smaller range of unrestricted choices. Consider this hypothetical case of a teenager with a leg amputation who chooses not to participate in activities at an amusement park. His decision may be motivated by two broad factors: it may simply be his authentic desire not to go out that day; on the other hand, he may desire to go to the park but chooses not to go because of park-related factors, such as limited accessibility.

If the park is well designed with infrastructure that makes it accessible to people with disabilities, his decision not to go is more likely to be authentic. It is reasonable to conclude that the fear of encountering accessibility issues does not influence his choice. Additionally, if the city has made reasonable efforts to provide a variety of accessible games, his decision cannot be attributed to a lack of gaming options. His vulnerability cannot be said to limit his autonomy because all options that can reasonably be availed to him have been made available to him. Although his options are less than those available to those without disabilities, they are not deliberately restricted and, in the context of this argument, are not limited.

Vulnerability diminishes autonomy when no reasonable efforts are taken to reverse the conditions that make one vulnerable and are allowed to make one feel unable to make free and informed decisions about their lives. This form of vulnerability puts individuals in positions where they cannot prevent occurrences that undermine what they deem important (Mackenzie C. , 2013; Anderson, 2014). For example, in the context of MAiD MD-SUMC, Canadians with mental illnesses are vulnerable in two aspects: first, due to the mere fact that they are living with chronic illness; and secondly, because of the unmet health and social inclusion needs. Their vulnerability is autonomy diminishing because not enough has been done to improve their access to mental health care, safe housing, and social inclusion. Efforts to mitigate the impact of these factors on the experience of mental suffering would not eliminate the vulnerability inherent to living with a mental illness. However, they would make this vulnerability less autonomy-diminishing.

Chapter Summary.

Using the social-relational notion of autonomy, this chapter has argued that inadequate mental health care, as well as the stigmatization that is endemic to those suffering from mental illness, can have coercive influence on MAiD MDSUMC requests. Drawing on Catriona Mackenzie's conditions for personal autonomy that emphasize access to a relevant range of options and control, it has been argued that without access to appropriate health care, Canadians with MD-SUMC do not have an adequate range of alternative options that allows critical reflection on their MAiD decisions. This general argument is buttressed by Catriona's view of autonomy as a status concept which is undermined by stigma and the systemic non-recognition it causes.

Chapter Four: A Justification for Paternalism.

Chapter Introduction.

Chapter three examined the effects of stigma and inadequate mental health care due to long wait times on the voluntariness of MAiD MDSUMC requests and argued that the two barriers can be autonomy diminishing. Chapter four furthers this discussion with a justification for the paternalistic prohibition of MAiD MDSUMC. This task is attempted in three steps, beginning with a brief and general description of what paternalism means. This is followed up with a criticism of the over-prioritization of uncritical autonomy over other equally important ethical principles in health care and finally, a justification of the paternalistic prohibition of MAiD MD- SUMC.

Paternalism.

Gerard Dworkin provided one of the most widely cited descriptions of paternalism as "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced" (Dworkin, 1972). Paternalism is associated with attitudes of over-protection that infringe on an individual's personal freedom and autonomy with the intent of benefiting them or protecting them from harm (Fernández-Ballesteros, 2019). It involves inducing others to behave in ways we consider to be good for them or hindering them from behaving in ways we consider to be bad for them (Scoccia, 2008).

There are various theoretical conceptualizations of paternalism by different writers. These include hard vs soft paternalism; broad vs narrow; weak vs strong; pure vs impure; and moral vs welfare paternalism (The Stanford Encyclopedia of Philosophy, 2020). The soft vs hard distinction is the conceptualization of interest in this chapter. Soft paternalism is the view that the only condition under which paternalism is justified is when it is necessary to determine whether the person being interfered with is acting voluntarily and knowledgeably (The Stanford Encyclopedia of Philosophy, 2020). Hard paternalism is directed towards actions or choices known with certainty to be voluntary and fully autonomous (Scoccia, 2008).

In liberal societies, paternalism is not popular as it is believed to control people's choices in ways that disrespect their autonomy and interfere with their ability to live according to their own reasoning (Conly, 2013). Beneficent interference is usually frowned upon—especially when it targets sufficiently voluntary behavior (Grill, 2012). Paternalism is deemed morally wrong as it imposes on an individual a conception of "what is right" or the "good life" that she may reject. Anyone that unjustifiably engages in paternalism toward a competent adult is thus faulted for lack of respect (Scoccia, 2008).

Paternalism raises conflict between two core values: self-determination and individual well-being. These values conflict when an individual chooses an action that is harmful to their well-being (Brock, 1988). Tension arises between individuals who want to exercise their right to self-determination and authorities concerned about the individuals' well-being (Thompson, 2013). To navigate these challenging situations, authorities must choose between infringing excessively on an individual's right to self-determination to protect him from harmful consequences of his own choices and respecting his autonomy which may lead to self-harm (Scoccia, 2008; Brock, 1988). They are usually faced with the daunting task of critically analyzing the situation to identify the value that is more important in the prevailing circumstances. Proper justification must be provided whenever the individual's well-being is prioritized over respect for their self-determination.

Despite the negative connotations of paternalism in liberal societies, it is permissible—and even required in some situations. For example, paternalistic policies are usually required to control infectious disease epidemics. Recently, competent adults were coerced to self-isolate, wear masks, get vaccinated, and stay in their homes without their consent for protection against COVID-19. Even the strongest anti-paternalists would admit that, without such measures, we would stand no chance in the fight against COVID-19. Paternalistic interventions are also uncontroversial when dealing with individuals believed to lack the competence or capacity to make autonomous decisions. These include those with severe mental illnesses, minors, and unconscious people.

In the scenarios above, paternalism is usually defended by claiming that the infringement on liberty is minor compared to the benefits they bring (or the danger they prevent) to the individual whose liberty is being restricted. Overall, it is expected that the person affected by the policy will be better off with such interference. Paternalism is also justified to protect third parties from the harmful consequences of the behavior of the individual whose liberty is being limited. For example, bans on smoking in public places and in cars while carrying minors are meant to protect non-smokers from the harmful effects of secondhand smoke (Wilkinson, 2021).

The debate about when paternalistic interference becomes justifiable heats up when such intervention is proposed outside of public health emergencies and severe mental incompetence or incapacity. Anti-paternalists demand satisfactory reasons for paternalist interference with the self-regarding actions of people that are neither incompetent nor ignorant. This is the task at hand in this chapter. It aims to show that MAiD-MDSUMC, despite being a choice of competent adults that mainly affects the chooser, is one of the scenarios in which soft paternalism is not only justifiable but required. I begin this task by finding issue with the uncritical over-prioritization of individual autonomy in liberal cultures at the expense of other ethical principles.

Autonomy vs Beneficence: Finding a Balance.

Paternalism usually involves conflict between two ethical principles: beneficence and respect for autonomy. Beneficence, as applied in medical ethics, is the obligation of the health worker to act for the benefit of the patient. The principle of beneficence also supports other actions outside clinical health care, like the protection of the rights of others and preventing harm (Varkey, 2021). Respect for autonomy requires that individuals are allowed or enabled to make their own decisions regarding their lives—even when these decisions seem irrational or contradict the health worker's recommendations (Sedig, 2016).

Historically, the principle of beneficence was given primacy over respect for autonomy. The general idea was that physicians knew what was best for their patients. It is now known that this idea was flawed; physicians might be experts about what a patient needs, but they are not experts about what a patient wants. Physicians err when they impose their idea of what a patient should want onto the patient. One potent example of how ethically perverse "over-prioritization" of beneficence can be is the well-known, widely studied case of Dax Cowart.

In 1973, Dax Cowart, a 25-year-old man, suffered severe third-degree burns (up to 65% of Total Body Surface area) from a propane gas explosion. He lost sight in both eyes, lost his hands, and his hearing was significantly impaired (Gerreck, 2018). Ten months into his treatment, Dax asked that all the painful, life-saving treatment be discontinued, asserting that he did not want to live as a blind and disabled person (Burton, 1989). His physicians did not halt the treatment. Instead, they sought psychiatric consultation with two independent psychiatrists, both of whom found Dax to be competent to make decisions regarding his treatment. Although Dax went on to heal from his injuries and pursue a career as an attorney, he still insisted that his decision should have been respected. Many bioethicists agree with Dax that his physicians behaved in an excessively overbearing manner when they forced him to endure painful treatments that he did not want. For many years, Dax has been used as a paradigm case to examine the tension between autonomy and beneficence—to answer the challenging question of who should be in control. Should any of the two parties have absolute control? I will return to this question later.

After the research atrocities of the Nazi physicians and the Japanese imperial army, the CIA brainwashing and Tuskegee studies, and famous cases like Dax's, respect for autonomy became the core principle of contemporary liberal ethics. Violation of patient autonomy is prima facie opposed unless strong arguments in favor of the violation can be made. This stand has been key in protecting patients' interests in managing their illnesses. However, modern societies have moved from prioritizing patient autonomy to uncritically overprioritizing patients' wants and demands. This practice poses different but equally serious threats to the ethical delivery of health services as the over-prioritization of beneficence. The superficial preoccupation of modern medicine with an absolute right to autonomy has turned health care into a consumer model of care where health workers merely serve as suppliers to appease and flatter their customers (Lepping, 2014). Uncritical prioritization of uncritical autonomy and what the patient "wants" has increased the risks of enforcing decisions made by patients who are inappropriately described as autonomous and ignoring the fact that acting in the patient's best interest is also key in health care (Breeze, 1998). It has also raised the danger of overlooking the obligation of health professionals to maintain moral integrity in the provision of care.

I would now like to return to where I started: who should be in control? I agree with (Lepping, 2014) that any serious ethical framework should consider all competing ethical principles without giving a priori preference to any particular one. In principles of biomedical ethics, Beauchamp and Childress postulated that all principles of medical ethics are meant to be considered equally when solving ethical dilemmas. The importance attached to each principle should change depending on the contextual factors at hand (Beauchamp & Childress, 2013). Each ethical principle should be taken as a prima facie obligation that needs to be fulfilled unless it conflicts with another principle. In such a case, the weight of the competing principles should be evaluated according to the context of the prevailing situation (Varkey, 2021). Therefore, the right to autonomy should not be absolute. Respect for autonomy, like other principles, should be weighed against competing principles and, when necessary, be overridden. In cases where an individual's decisions are believed to be motivated by flawed reasoning, beneficent intervention should not be trumped by the uncritical preoccupation with autonomy (Woodward, 1998).

Excluding Canadians with mental illness from utilizing MAiD on the grounds that it is not in their best interests might bring flashbacks from Dax's case to the mind of the anti-paternalist who advocates for the right to autonomy. It is, however, important to note that the prohibition of MAiD- MDSUMC would in no way be similar to the intrusion with personal autonomy in Dax's case. This is because Dax, unlike Canadians with MD-SUMC, had received the appropriate treatment when he made his decision. Suppose that Dax, after suffering severe burns, had sought to be admitted to a specialized burns unit only to be given pain medication and asked to wait "in line" for an extended period. After waiting for what feels like forever, Dax decides that he has had enough and requests that the painkillers be stopped and that he is allowed to access medically assisted death. Would it be ethically permissible to respect Dax's decision? I argue that it would not—even when arrived at in a procedurally correct manner.

Let us revisit some true events in Dax's story. After sustaining the severe burns, Dax's first request to the first responder, a farmer, was to give him a gun to kill himself. To quote (Gerreck, 2018), Dax said, "Get me a gun. Can't you see I am a dead man? I am going to die anyway". The farmer did not honor Dax’s request. By refusing to hand Dax a gun, he behaved paternalistically toward Dax. It is reasonable to assume that the farmer’s reasoning was similar to ours; in that moment of severe distress, Dax might not have been his real self. His request to die could not be truly ascertained to be his authentic desire. The farmer’s paternalist interference with Dax’s liberty was thus justified. The best and only way to respect Dax’s autonomy—and ascertain if his desire to die was authentic—would be to surround him with conditions that would promote or enhance his critical autonomy. This was done by offering him the appropriate treatment. After accessing specialized burns treatment, Dax’s request stuck. From this point on, denying his request to have treatment discontinued became ethically problematic.

Canadians with mental illness are like the hypothetical Dax waiting in line on painkillers without specialized treatment for his burns—or the real Dax who requested a gun right after his freak accident. Dax, in both cases, is displaying uncritical autonomy. Extension of MAiD to Canadians with MDSUMC on the grounds of respecting their autonomy would be similar to the farmer handing Dax a gun—or granting his wish to die after denying him proper treatment. It would amount to uncritical prioritization of uncritical autonomy and would be ethically problematic. Although competent, Canadians with MDSUMC are undergoing what I refer to as "autonomy failure" due to the healthcare constraints surrounding them. If the motivation is to enhance their critical autonomy, it is justifiable to restrict their access to MAiD temporarily.

Enhancing Critical Autonomy: A Justification for soft paternalism.

It has already been established that autonomy is intricately associated with paternalism (Sullivan, 2018). This association arises from liberal theories like Mill's (1956)'s, that support the human interest in pursuing an autonomous life, with full and absolute control over the design and path of their personal lives. Mill is supported by other scholars like Donald van de Veer (1986), Richard Arneson (1980), and Joel Feinberg (1986), who all agree that informed and self-regarding choices are protected against paternalistic interference by autonomy. An agent's right to personal autonomy and self-determination is the major liberal objection to paternalistic interference (Hanna, 2012). However, this objection is problematic because it is overly dependent on conceptualizing autonomy as individualistic.

As has been argued in chapter three, the theory of autonomy as a strictly individual attribute is dangerously narrow because it ignores factors external to the chooser that significantly affect his decisions. This view of autonomy leaves little to no room for beneficent interference with a competent chooser's actions that do not significantly affect third parties. Yet, in some cases, this interference is necessary to enhance the chooser's autonomy and to enable him to attain his long-term goals. The contrasting view of autonomy as relational opens room for such interference. I will return to this point later. First, I want to make clarificatory remarks about other concepts of autonomy that are key to the plausibility of this discussion.

Autonomy is a broad phenomenon that can be conceptualized in numerous ways beyond individualistic vs relational. Two other conceptualizations that are relevant to this argument are principled vs practical. The view of autonomy as principled takes autonomy to be a legal right. An individual either has it or it is stripped from him. Feinberg likens this conception of autonomy to a nation's right to govern its territory (Le Grand, 2015). Autonomy can also be viewed as practical—the kind that is dependent on an agent's prevailing situation and circumstances. We can possess practical autonomy, lose it, and regain it (Pullman & Hodgkinson, 2016). Practical autonomy is not seen as an all-or-nothing concept that, if one possesses, can make every decision and will fail to make any decisions if one lacks it. The view of autonomy as practical acknowledges that an agent can have the capacity to perform a certain action, while that same capacity may not be enough to perform another action. For example, an individual with a severe mental illness might not be able to consent to medical procedures. They may, however, have the capacity to decide what meal they want. Regarding decisions about their medical care, this individual's autonomy fails. However, it survives as regards other, simpler decisions. Practical autonomy is, therefore, a matter of capacity and degree. It is practiced on a continuum.

The plausibility of the justification for paternalistic prohibition of MAiD- MDSUMC in this section rests on the conceptualization of autonomy as relational and practical. These two concepts show that we can have, lose, and regain our autonomy due to the socio-relational factors surrounding us. Also, due to these same factors, we can make autonomous decisions about some things while our autonomy may fail about others.

Autonomy failure results from anything that stops us from meaningfully pursuing our goals. It can be due to severe medical conditions like degenerative neurological disorders, mental disorders, and cerebrovascular accidents. It also occurs when one is subject to conditions or processes that alter one's goals without necessarily altering the mental competence to pursue them (Edwards, 2010). The latter cause of autonomy failure is what is of relevance to soft paternalists who disagree that the new goals are truly voluntary and, therefore, paternalism-proof. They argue that an individual only acts voluntarily if he does not choose under circumstances that are temporarily distorting (Hanna, 2018). Since soft paternalism is justified if a person's conduct is substantially non-voluntary—or to establish whether the conduct is voluntary—they see an opening for interference to protect the meaningful goals the chooser had before the distorting factors alienated them from these goals. This action aims to minimize all non-voluntary behaviour that leads to significant harm that the chooser has not truly chosen to suffer (Feinberg, 1986).

The soft paternalist also intervenes to enhance and preserve future autonomy and goals. This intervention is justified when others cannot make an autonomous decision and when they are about to make a substantially impaired choice. Here, the soft paternalist focuses on the individual's long-term goals. Paternalistic intervention is meant to be in line with what the agent wants to accomplish—not what the soft paternalist thinks the agent should want to accomplish (Butkus, 2013). Although life goals are person-specific, there are a few commonly shared goals for which it is reasonable to generalise to most people (Conly, 2013; Butkus, 2013). Proper health care for one's illness is an example of a commonly shared goal. If inadequate health care is consciously or unconsciously impairing the reasoning of the sufferer, soft paternalists feel justified to interfere to remove the impairment. Sometimes, the intervention involves delaying this choice until the impairment is removed or until it is clear that the choice is not impaired. This makes the future choices of an agent more autonomous and helps him achieve his long-term goals.

Pullman and Hodgkinson (2016) illustrate the argument above well with both hypothetical and real cases. In the event that one is unable to make an autonomous decision, they use a hypothetical example of an unconscious patient who is rushed to the emergency department. Clinicians are justified in treating him without consent to restore him to a state where he can exercise his autonomy and pursue his long-term goals. In situations where there is suspicion that one's decision is substantially impaired, they give an interesting real-life account of a young patient who demanded to have a life-saving cardiac device (implantable cardioverter defibrillator) removed from his body despite having saved his life at least two times. With the removal of the device, he was almost certain to suffer a life-threatening cardiac event within two years. Despite being armed with such knowledge, he insisted on removing the device. The team involved in his case delayed the ICD removal. There were multiple reasons for the delay, but only two are relevant here. First, it was to ensure that his choice was stable and strongly held. Secondly, they wanted to allow him more time to gather more information and reflect on the possible repercussions of his choice, which was a way of enhancing his critical autonomy.

Pullman and Hodgkinson (2016) note that it is justifiable to intervene in a way that addresses the conditions undermining an agent's autonomy to restore it. They make a persuasive argument that while authorities are obliged to respect the principled and legal autonomy requirements, they are also obliged to protect and enhance practical autonomy. They note that such an understanding opens the door to paternalist interventions even in conditions where the individual whose decision is being interfered with is deemed competent in principle.

There are two objections to paternalism worth addressing. The first is that paternalist interventions impose foreign goals onto the chooser under the veil that the goals they have chosen to pursue are not their real goals (Begon, 2016). While this argument might hold against hard paternalism, it fails against soft paternalism. This is because soft paternalism rests on the paternalist being unsure about the true goals of an agent after being given satisfactory reasons to doubt the authenticity of the goals the agent is pursuing. It is not possible to impose foreign values onto someone whose values you are not sure of. Reconsider the two Canadians, Denise and Amir, who simultaneously expressed their desire to stay alive while applying for MAiD. Without solving homelessness, a main contributor to their suffering, it is impossible to know their true goal. Delaying their request for MAiD does not amount to imposing foreign values onto them because it is not clear what their authentic goal is. Their desire to die can only be considered strongly held and true if it sticks after the removal of homelessness as a contributor to their despair. Denial of their MAiD requests while no longer homeless is the only way paternalist intervention imposes foreign values onto them. If the desire to die sticks after removing what the paternalist suspects to be the cause of impaired reasoning, it can be considered the chooser's authentic goal. As argued earlier, the soft paternalist aims to help the agent achieve his true long-term goals, a process that begins with identifying these goals. During this process, the soft paternalist can not be charged with imposing foreign values onto the agent.

The pro-paternalism argument is vulnerable to another objection that such interference is unjustifiable for Canadians with mental illness whose desire to die by MAiD is free from external influences and, therefore, sufficiently autonomous. This argument aligns with the reasoning of the Supreme court of Canada in Carter v. Canada, where it recognized that section 241(b) of the criminal code was too broad, infringing upon the fundamental rights of vulnerable and non-vulnerable Canadians alike. Consequently, the enacted MAID legislation included safeguards aimed at protecting vulnerable Canadians.

While these safeguards have largely shielded vulnerable Canadians with physical illness, they are inadequate in offering similar protection to Canadians with MDSUMC. For example, unlike the Netherlands and Belgium, physicians in Canada are not explicitly required to have a long-standing relationship with the MAiD applicant. A mere 90 days is deemed sufficient for physicians to gain comprehensive understanding of the MAID MDSUMC applicant while processing their request. The absence of a well-established familiarity with the applicant's mental health history restricts the assessor's ability to conduct a thorough evaluation of the intricacies surrounding the applicant's situation. Furthermore, there is no rigorous framework to investigate cases of suspected external pressure during these 90 days. This makes it challenging to satisfactorily and consistently differentiate between applicants whose suffering primarily stems from socio-relational factors from those whose suffering is attributable to the underlying mental illness. Such challenges make selective provision of MAiD MDSUMC difficult.

How Much Involuntariness Warrants Paternalist Intervention?

So far, I have argued that beneficent interference is justified when one is believed to be acting involuntarily and if significant harm is being prevented. The voluntariness of a decision is questioned if it is taken under distressing conditions and if the chooser, at any point in their decision-making process, shows any indication that they would not have made this decision if the conditions surrounding them were different. This argument raises more interesting questions: How much involuntariness is too much to warrant paternalist intervention? When is an individual's action considered sufficiently voluntary to be immune to paternalistic interference? There is no conclusive answer to any of these questions. It would be an insurmountable challenge to argue that (in)voluntariness can be measured by a given metric to determine if it is enough to warrant or resist paternalism. Nevertheless, some scholars have endeavored to answer these hard questions.

Feinberg argues that one way to judge how much (in)voluntariness is too much is to weigh it against some properties of the action that is about to be committed. Three properties are relevant here. First, the probability that harm will result from the action. Secondly, the severity of the expected harm. Lastly, the permanency of the expected harm. He notes that the level of voluntariness needed for an action should increase with the likelihood of a harmful result. It further increases if this harm is severe and rises more if this harm is permanent (Feinberg, 1986). Goodin (1993) agrees with Feinberg that voluntariness should increase with increasing irrevocability of an action. This is because any mistakes that might result in misjudging the voluntariness of engaging in an irrevocable harmful act are final and irreversible. It is justifiable—and even required that more care is taken to ascertain the voluntariness of such actions. Paternalism is, therefore, more defensible when directed toward irrevocable self-endangering choices—especially if the motivations for such choices are murky.

For illustrative purposes, let us adjust Dworkin's example of the man on the bridge. Dworkin used a hypothetical scenario to explore the limits of paternalism. In this scenario, he asked the reader to imagine walking by a man about to jump off a bridge, only to find out that the reason behind the suicide attempt is financial hardship. Dworkin argues that, while this man's decision may appear irrational, it is still his decision to make. For the purpose of argument, let us modify Dworkin's example and presume that this man is emotionally distressed and is trying to cross a rotten bridge.

If the bridge crosses a shallow stream where an adult is not expected to drown, a public officer might caution him about the faulty bridge but will most likely make no attempts to restrain him from crossing the bridge to ascertain if this is what he really wants. This is because the public officer knows that the most probable harm the man could suffer is wetting his clothes and, at worst, fracturing his limb, depending on how the slip off the bridge goes. Although the likelihood of him slipping off the bridge is high, the probability of severe harm is low. The anticipated harm is also reversible.

The voluntariness required to cross this bridge is lower than what would be required if he was trying to cross a high bridge across a fast-flowing turbulent river with sharp rocks. Restraining this man to ascertain if he really wants to cross the bridge would be defensible because we know that he is most likely to be swallowed up by the roaring waters, struck against sharp rocks and probably never be seen again.

There may be reasons beyond mere innocent ignorance and emotional agitation why this man might be crossing a dangerous bridge; he might be a daredevil who derives pleasure in highly risky activities. However, given the unusualness of his decision, and the severity and irrevocability of a highly probable negative outcome, a higher degree of voluntariness is required. As morally serious beings, we are required to ascertain that he is not acting out of ignorance or distortion of reasoning. Although paternalist intervention is justified in both cases, the justification is stronger in the second case because of the nature of the anticipated harm.

Chapter Summary.

Despite being frowned upon in liberal cultures, paternalism is sometimes not only justifiable but required. Generally, paternalistic interference faces less opposition when directed toward incompetent individuals, during public health emergencies, and in situations that raise the need to protect third parties from the harmful behavior of those whose liberties are being restricted. Paternalistic intervention, however, faces deep scrutiny when imposed on competent adults whose behavior does not place any third parties at risk of significant harm. This chapter has presented justification for the paternalistic prohibition of mentally competent Canadians from accessing MAiD-MDSUMC. It has briefly explored the meaning of paternalism, argued against an absolute right to autonomy, demonstrated that the autonomy of Canadians with MDSUMC fails regarding MAiD, and illustrated why MAiD MDSUMC requests do not currently qualify as voluntary enough to be immune to paternalistic interference.

Thesis Summary.

This thesis has examined the validity of the autonomy of Canadians with mental illness as their sole underlying condition regarding their request for a medically assisted death. It has argued that socio-relational barriers faced by Canadians with mental illness worsen the experience of mental illness and constrain their exercise of autonomy. Specifically, it has explored two barriers: a lack of access to adequate mental health care and the stigma associated with mental illness. The prevalence of these two barriers has been presented, and it has been argued that they are at levels high enough that they could well act as controlling influences for Canadians with mental illness, coercing some to request MAiD.

The argument for the autonomy-diminishing effect of these barriers rests on the socio-relational notion of autonomy, which holds that autonomy is exercised within the complex web of our social-relational health determinants. Two real-life case studies of Canadians with ill mental health requesting MAiD due to the lack of (or the fear of losing) safe housing have been presented to underscore the coercive effect of socio-relational factors on decisions to request MAiD. The thesis has also launched a critique of the contrasting view of autonomy as hyper-individualistic. This view confines the exercise of autonomy to two main procedural requirements: having the mental capacity to make autonomous decisions and being free from direct coercion.

Finally, the thesis has defended the paternalistic prohibition of access to MAiD MD-SUMC. It has argued that soft paternalism is justifiable if there are sufficient reasons to suspect autonomy failure. Autonomy failure occurs when one is stopped from meaningfully pursuing their authentic goals or is subjected to conditions that alter them. It has asserted that inadequate access to health care and stigma are strong enough reasons to alter the goals of Canadians with mental illness and that paternalistic interference is justified to ascertain the voluntariness of their choice to die with dignity amidst barriers to living with dignity.

Conclusion

The thesis has provided a theoretical analysis of the ethical implausibility of providing death as an option to people whose suffering is significantly exacerbated by societal factors that remain unresolved. This analysis contributes to the ongoing debate about MAiD-MD-SUMC in Canada and can guide policymakers in deliberations on the ethical considerations of offering MAiD MD-SUMC. Furthermore, this analysis can serve as a starting point for future research on the determinants of mental suffering among Canadians with mental illness. Such research would not only aid in the prompt, comprehensive and effective provision of mental health care, but would also help ensure that any potential policy regarding MAiD MD-SUMC is responsive to the actual needs of Canadians with mental illness.

Although the government and health authorities have a responsibility to respect individuals' autonomous decisions, they also have a duty to protect the vulnerable and promote their autonomy. Providing MAiD MDSUMC in the current mental health care climate would be ignorant of the reality of suffering among Canadians with mental illnesses and would amount to abandoning the vulnerable. The government would be respecting the uncritical autonomy of Canadians with MD-SUMC—a decision that is not ethically sound. Delaying the provision of MAiD MD-SUMC[6] until reasonable efforts have been taken to address inadequate mental health care and stigma surrounding mental illness is only way to fulfill both duties to the vulnerable and non-vulnerable Canadians.

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[6] At the time of writing this section, the federal government had introduced Bill C-39, which proposes the extension of the temporary exclusion of the eligibility for MAiD where a person's sole underlying condition is a mental illness until March 17th, 2024.

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