

Interpreting Irremediability When a Mental Health Disorder is the Sole-qualifying Medical Condition for MAiD

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Volume 5, numéro 4, 2022

URI : <https://id.erudit.org/iderudit/1094700ar>

DOI : <https://doi.org/10.7202/1094700ar>

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Éditeur(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (numérique)

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Kirby, J. (2022). Interpreting Irremediability When a Mental Health Disorder is the Sole-qualifying Medical Condition for MAiD. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, 5(4), 83–88. <https://doi.org/10.7202/1094700ar>

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COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Interpreting Irremediability When a Mental Health Disorder is the Sole-qualifying Medical Condition for MAiD

Jeffrey Kirby^a

Résumé

Dans ce commentaire critique, un ensemble de considérations éthiques pertinentes à l'interprétation (actuellement contestée) de l'irrémediabilité aux fins de l'évaluation de l'aide médicale à mourir dans les cas où la seule condition médicale sous-jacente est un trouble de santé mentale est exploré et analysé. Sur la base de cette application d'une lentille éthique, une description pratique de l'irrémediabilité est proposée pour être utilisée comme guide par les cliniciens canadiens en soins de santé mentale, les évaluateurs et les fournisseurs d'AMM, et les autorités de réglementation professionnelle provinciales et territoriales.

Mots-clés

irrémediabilité, aide médicale à mourir, AMM, santé mentale, éthique

Abstract

In this critical commentary, a set of ethical considerations of relevance to the (currently contested) interpretation of irremediability for medical assistance in dying (MAiD) in circumstances where the sole-underlying medical condition is a mental health disorder is explored and analyzed. Based on the application of an ethics lens, a practical description of irremediability is proposed for intended use as guidance by Canadian mental health care clinicians, MAiD assessors and providers, and provincial/territorial professional regulatory authorities.

Keywords

irremediability, medical assistance in dying, MAiD, mental health, ethics

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INTRODUCTION

There has been considerable and fractious debate in Canada over how the irremediability element of the “grievous and irremediable health condition” eligibility criterion will be interpreted and applied by medical assistance in dying (MAiD) assessors and provincial/territorial (P/T) professional regulatory authorities after mid-March 2023, once requestors whose sole-underlying health condition(s) is a mental health disorder(s) can request MAiD (i.e., when the relevant Bill C-7 sunset clause expires). There is a wide spectrum of opinion regarding this matter among clinicians, relevant professional associations, health law and healthcare ethics academics, MAiD activists and persons with lived experience of mental health disorders (1). On one end of the spectrum that I address in this commentary are: 1) those who oppose the provision of MAiD in these particular circumstances but who recognize and acknowledge that access to MAiD in circumstances where a mental health disorder is the sole-underlying medical condition (MD-SUMC) will become a reality in Canada after mid-March 2023, and 2) those who are not philosophically opposed to MD-SUMC as a strong commitment but are of the opinion that all available, standard-of-care treatments and interventions must have been adequately explored, and have demonstrably failed, before making a finding of irremediability. On the other end of the spectrum are those who believe that there should not be a requirement that any standard-of-care treatments and interventions have been tried or used in order for a finding of irremediability to be met. The opinions of others actively engaged in the debate fall somewhere between these two polarized views.

My own views about this issue have been influenced and informed by my healthcare ethics academic work in the domain of assisted dying, relevant discussions and deliberations with ethicists, health lawyers and practicing clinicians including Canadian MAiD assessors and providers, and my recent, dynamic engagement as a member of the Expert Panel on MAiD and Mental Illness that was jointly appointed by the federal Canadian Ministers of Health and Justice to make recommendations regarding possible, additional MD-SUMC legislative safeguards and guidance.

In this critical commentary, I briefly provide some historical information about how irremediability has been framed to date in a relevant Canadian Supreme Court decision and in international assisted-dying legislation. I then explore and apply an ethics lens to some significant considerations that are relevant to the optimal interpretation of irremediability in the MD-SUMC context. Finally, I propose a practical description of irremediability to assist in its interpretation by Canadian mental health care clinicians, MAiD assessors and providers, and P/T professional regulatory authorities.

Note that my use, here, of the term (and conception of) ‘irremediability’ encompasses both: 1) a consideration of the length of time of the requestor’s inadequately relieved, profound, psychiatric suffering and, 2) a consideration of the requestor’s demonstrably inadequate-over-time, therapeutic responses to appropriate, multimodal, clinical interventions. Both of these interconnected elements are captured in the proposed, practical description of irremediability in the MD-SUMC context.

HISTORICAL BACKGROUND

In the 2015 Supreme Court of Canada (SCC) judgment *Carter v. Canada (Attorney General)*, which significantly informed subsequent Canadian MAiD legislation, ‘irremediability’ is referenced in the descriptive wording of a grievous and irremediable medical condition (2). The SCC decision includes the statement that a finding of irremediability “does not require the patient to undertake treatments that are not acceptable to the individual.” However, it is important to note that this pronouncement is qualified and limited by a statement that the scope of the declaration “is intended to respond to the factual circumstances of the case”, i.e., the clinical circumstances of a plaintiff whose profound suffering arose primarily from a physical health disorder. There is an ancillary statement in the judgment that the court “makes no pronouncement on other situations where physician-assisted dying may be sought”. In relevant Canadian legislation, i.e., Bill C-14 (3) and Bill C-7 (4), irremediability is also framed as a component of the MAiD eligibility criterion of a grievous and irremediable medical condition within three (surviving in Bill C-7) sub-criteria that are independent of one another, i.e., the presence of: a) a serious and incurable illness, disease or disability, b) an advanced state of irreversible decline in [functional] capacity, and 3) enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that the requestor considers acceptable. Within these sub-criteria, relevant adjectives and phrases of relevance to irremediability include “incurable”, “advanced state of irreversible”, “enduring” and “cannot be relieved”.

Irremediability is similarly framed in pioneering Dutch and Belgian legislation. Two of the due care criteria of the Dutch *Termination of Life on Request and Assisted Suicide Act* (2002) state that “there is no prospect of improvement” and that “there is no reasonable alternative in light of the patient’s situation” (5). Of relevance to a finding of irremediability, the *Belgian Act on Euthanasia* (2002) states that the person must be “in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated” (6). There are also references in the Belgian legislation of the requirement for providers of euthanasia to be certain of the “durable nature of [the] request” and that “together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient’s situation”.

RELEVANT ETHICS CONSIDERATIONS

It is widely recognized that the topic-domain of assisted dying, considered broadly, has important ethics elements and dimensions. However, these are rarely identified and articulated as such in the literature and lay press. I have previously published a described set of MAiD ethics substantive principles and values (which are of relevance to the development of government health legislation and macro- and meso-level MAiD policies through the use of deliberative engagement methodologies), i.e., individual autonomy, health equity, nonmaleficence and social justice, beneficence and duty-of-care, conscience and professional autonomy, non-abandonment and continuity-of-care, professional competency, and accountability and oversight (7). In this commentary, I focus on the relevance of some of these substantive principles and values and other, pertinent ethics considerations to the development of an optimal interpretation of irremediability in the MD-SUMC context.

Considerations of formal justice, commonly attributed to Aristotle, played a major role in development of Bill C-7. Simply stated, formal justice requires that like individuals and groups of persons be treated the same and dissimilar individuals and groups of persons be treated dissimilarly. The fundamental corollary is that individuals and groups should be treated the same unless a relevant difference(s) between/among them can be demonstrated that justifies the dissimilar treatment. This construct is typically framed, in Canada, in terms of protections in the *Canadian Charter of Rights and Freedoms* (Section 15) for members of certain, specified groups against discrimination, i.e., persons have a right to equal protection and equal benefit of the law without discrimination (8).

The government developers of Bill C-7, following the 2019 *Truchon v. Procureur général du Canada* decision of the Superior Court of Quebec, considered that there were insufficient relevant differences between MAiD requestors whose death is not reasonably foreseeable and those whose death is reasonably foreseeable to exclude the former group of persons from access to MAiD (9). They did, however, consider that there were insufficient relevant differences between these two requestor-groups to establish separate, eligibility-assessment tracks such that more safeguards are applied in circumstances where death is not foreseeable. Similarly, Bill C-7 developers came to believe after stakeholder-informed, comprehensive input to the House of Commons and Senate that there was not enough of a relevant difference between requestors with underlying physical health disorders and requestors with underlying mental health disorders to deny the latter group access to MAiD indefinitely in the future. However, they were of the opinion that there were enough relevant differences between these two requestor-groups to warrant the insertion of a sunset clause into Bill C-7; this clause would provide enough time for an expert panel jointly appointed by the Ministers of Health and Justice to develop recommendations regarding an additional set of legislative safeguards and guidance to be applied during MAiD assessments in the evaluation of MD-SUMC requests, after mid-March 2023.

I agree with the development and use of additional, legislative safeguards and guidance for requestors whose sole-qualifying health condition(s) is a mental health disorder(s). In my view, legitimate relevant differences between the two groups of requestors that adequately justify the use of additional safeguards and guidance in the case of MD-SUMC include (on relative bases):

- 1) greater complexity of assessments of decisional capacity and irremediability in requestors, with the related clinical reality that practitioners of only one medical specialty, i.e., psychiatry, are optimally qualified to perform such evaluations,
- 2) greater possibility of evaluation-challenges secondary to cognitive distortion or the suboptimal development of insight into the person's health condition,
- 3) less prognostic clarity in some circumstances,
- 4) reduced number of observable, objective findings associated with the expression of suffering,
- 5) suboptimal knowledge of the full scope of standard-of-care and innovative treatments and interventions for mental health disorders by primary health care providers, and
- 6) the possibility of a desire-to-die being a directly arising symptom of some mental health disorders, e.g., treatment-refractory major depressive disorder (10).

Requesters whose sole-underlying health condition(s) is a mental health disorder(s) will be able to request and, in some cases, access MAiD after mid-March 2023 in Canada. One of the important MAiD-related tasks for the federal government in 2022 and early 2023 is to ascertain (informed by considerations of the expert panel's recommendations regarding additional safeguards and guidance and subsequent relevant, stakeholder input) how irremediability should be interpreted in the MD-SUMC context by MAiD assessors and P/T professional regulatory authorities.

ETHICAL UNDERPINNINGS OF THE SPECTRUM OF VIEWS ON IRREMEDEIABILITY

As briefly mentioned earlier, there is a broad spectrum of opinion regarding how irremediability should be interpreted in the MD-SUMC context. Although irremediability evaluations are theoretically prospective, they rely on retrospective history and facts, including the demonstrated failures of access to appropriate treatments and interventions. On one end of the spectrum are proponents of a permissive interpretation of irremediability who believe that there should not be a requirement that any standard-of-care treatments/interventions for the requestor's particular mental health disorder(s) have been tried and failed in order for a person to qualify for MAiD in MD-SUMC circumstances. The arguments of MAiD activists, psychiatry clinicians and academics at this end of the spectrum tend to prioritize and primarily justify their view on the basis of the widely accepted ethical principle of respect for persons, in the form of individual autonomy, and an appeal to the promotion of health equity (11). With regard to individual autonomy, a person has the right, and should have the opportunity, to make meaningful decisions about their life plans, including choices about their health care and treatment. When considered in isolation (without the concurrent consideration of other relevant, substantive principles and values) individual autonomy provides an argumentative basis for the promotion of a permissive interpretation of irremediability in which there is no requirement that MD-SUMC requestors have tried and failed standard-of-care treatments and interventions for their underlying mental health disorder(s). Canadian MAiD activists and psychiatry clinicians at this end of the spectrum have attempted to support their position by referencing the relevant 2015 SCC judgment (2). However, making such an argument from authority is somewhat disingenuous given that, as described earlier, the SCC decision was explicitly limited to the scope of circumstances of a plaintiff whose profound suffering arose from a physical health disorder.

Health equity in socialized health care jurisdictions concerns itself primarily with identifying and eliminating or mitigating unfair barriers and obstacles to the access of persons to publicly-funded health/social care and (good) health. A claim on the basis of health equity in MD-SUMC circumstances requires that the existing or proposed disparity between the access of two or more groups of persons to health care that proponents of a permissive interpretation of irremediability identify and wish to eliminate or mitigate is unfair. So, in this particular context, the question arises as to whether it would be unfair after mid-March 2023 to implement a safeguard requirement that MD-SUMC requestors have tried and failed treatments and interventions falling within the scope of the existing standard-of-care for their underlying mental health disorder(s) in order for them to access MAiD (without a similar safeguard requirement being implemented for requestors with qualifying physical health disorders whose death is not foreseeable). My prior comments related to relevant formal justice considerations tend not to support a finding of obvious health inequity in this context given that a set of legitimate, relevant differences can be identified and articulated that justify the use of different, somewhat-more-restrictive safeguards in MD-SUMC circumstances than in physical health disorder circumstances.

At the other end of the spectrum of opinion, some Canadian psychiatry clinicians and professional bodies have expressed their strong view in favour of a restrictive interpretation of irremediability in which all treatments and interventions falling within the scope of existing standard-of-care available to the requestor should have been tried for adequate periods of time and demonstrably failed before a finding of irremediability is met in MD-SUMC circumstances. For example, the Canadian Psychiatric Association (CPA) has stated that MAiD documentation in MD-SUMC circumstances should demonstrate that: 1) standard treatments, including pharmacological, psychotherapeutic and non-pharmacological therapies for the specific, qualifying mental disorder(s) have been offered and used for a sufficient period of time, and 2) there are no other accessible, reasonable alternative treatments/interventions. Proponents of a restrictive interpretation employ in their argumentation one legitimate version of the principle of nonmaleficence (health care providers are obliged to do as little as possible harm to their patients) where the harm to be avoided is a foreshortened life. However, proponents of a permissive interpretation of irremediability could counter that the maleficence-related harm to be eliminated is ongoing, profound suffering.

A particular version of social justice can also be used to support the claim of proponents of a restrictive interpretation of irremediability. Social justice requires us to pay particular attention to the interests and needs of persons who are members of historically marginalized and otherwise disadvantaged social groups, and to include and support such members in policy-level decision making that directly affects them (12). Proponents of a restrictive interpretation of irremediability could claim that there is a social justice obligation to ensure that MD-SUMC requestors who are members of these disadvantaged social groups: 1) are not over-represented in MAiD requests (safety consideration 1), and 2) are adequately protected from the harm of a foreshortened life (safety consideration 2). However, proponents of a permissive version of irremediability could counter with a social-justice-based argument that mechanisms should be in place to ensure that MD-SUMC requestors, who are members of disadvantaged social groups, are optimally supported to make their own health-related decisions including a request for a medically assisted death.

There is an important, ethical requirement in developing government health legislation and health policies to identify any competing obligations that arise from the concurrent application of relevant, non-lexical, substantive principles and values through a process of deliberative engagement. Core stakeholders with the support of relevant resource persons can then deliberate through a facilitated, dialogical process to decide how to optimally weigh and balance these obligations in the development of the content of health legislation and meso/macro-level health policies. As described earlier, legitimate, ethical obligations that arise from isolated considerations of relevant substantive principles and values can be identified and articulated to support both permissive and restrictive interpretations of irremediability in the MD-SUMC context, e.g., individual autonomy and a version of non-maleficence where the harm is a foreshortened life. The effective, fair balancing of these obligations through a deliberative engagement process requires that deliberators decide to set the irremediability threshold somewhere in the middle range of the irremediability spectrum, between the previously described polar positions about the trial and failure of available, standard-of-care treatments and interventions for the requestor's particular mental health disorder(s). This equates, in practical terms, to a requirement that MD-SUMC requestors have adequately tried some, but not necessarily all, of the available, multimodal, standard-of-care treatments and interventions for their qualifying mental health disorder(s). In my view, where MAiD assessors (in dialogic collaboration with the requestor) land in their decision making in MD-SUMC circumstances (in particular cases about the required variety and number of multimodal treatments/interventions that requestors must have adequately tried and failed) should be left to the professional discretion of an independent psychiatrist in their role as one of the two MAiD assessors. This view informs the content of the practical description of irremediability in the MD-SUMC context proposed in the next section.

Other key, pragmatic irremediability elements and factors include the required lengths of time of both the requestor's experience of profound suffering and the treatment/intervention trials, and who should have the responsibility to assess irremediability in this particular MAiD context. In my view, given their training and experience, only psychiatrists are in an optimal position to: 1) assess the decisional capacity of MD-SUMC requestors, i.e., perform thorough capacity assessments in these complex, high-stakes circumstances, 2) be aware of, and be able to inform, the requestor of the full scope of existing, multimodal, standard-of-care and innovative treatments and interventions for their particular mental health disorder(s), and 3) determine the adequacy of the length of time the requestor has experienced profound suffering (which is framed as 'years', i.e., a minimum of two years, in the proposed, practical irremediability description) and the lengths of the past trials of the available, accessed treatments and interventions.

I am of the strong opinion that in order to eliminate possible bias-related influences of common psychotherapeutic dynamics (e.g., counter-transference) on MAiD assessment and eligibility decisions, MD-SUMC psychiatrist assessors should be completely independent, i.e., 1) do not currently have and have not had in the past a therapeutic relationship with the requestor, 2) have no past or current professional or personal connections with the requestor's attending health care providers (13). In order to ensure the cross-Canada implementation of the requirement that one MAiD assessor be an independent psychiatrist, a legislative safeguard to this effect – i.e., in the form of an amendment to Bill C-7 – should be made prior to mid-March 2023. This could be achieved by a one sentence addition to Section 241.2 (3,2) (e.1) (4). Implementation in all Canadian provinces and territories cannot be ensured if this recommendation is only offered as guidance, because this leaves possible implementation of the recommendation up to individual P/T jurisdictions.

Although a psychiatric professional association in the Netherlands recommends that there should be two independent psychiatric assessments in these circumstances, I do not believe that this is appropriate for the Canadian context. A requirement that more than one assessor be a psychiatrist, or that an additional psychiatrist must be consulted, could pose an unnecessary, inequity-related barrier to the access of MD-SUMC requestors to MAiD, given that, at least initially, the national pool of Canadian psychiatrists who are willing to perform MAiD assessments will likely be small. However, this should not be used as a reason not to add this important safeguard to Bill C-7 through a relevant, legislative amendment. For example, the recent Covid-19 pandemic showed that comprehensive psychiatric evaluations can be performed virtually by psychiatrists, i.e., without the need for an in-person meeting of the psychiatrist with the person (13), thereby facilitating timely and equitable access to psychiatric evaluations.

In my view, in the Canadian context, the two MAiD assessors should make the ultimate decision with regard to whether the requestor meets the eligibility criteria for MAiD MD-SUMC. The responsibilities of prospective, evaluative mechanisms should be limited to a careful process review to ensure that all procedural requirements have been met prior to the provision of MAiD when relevant eligibility criteria are determined by the assessors to have been met. The implementation of formal review panels

or boards, which have veto power over assessors' decisions regarding eligibility, imposes an unfair, inequitable barrier to the access of qualified requestors to MAiD MD-SUMC.

A PRACTICAL DESCRIPTION OF IRREMEDEIABILITY FOR MD-SUMC ASSESSMENT PURPOSES

The brief legal wording and phraseology of relevance to irremediability in the three eligibility sub-criteria of a serious and irremediable medical condition in Bills C-14 and C-7 (see below Note 2) does not, in my view, provide sufficient practical direction to Canadian mental health care clinicians, MAiD assessors and providers, and P/T professional regulatory authorities in the MD-SUMC context. With this in mind, and with the meaningful input of academic and clinical colleagues, I propose the following practical interpretation of irremediability for MD-SUMC MAiD assessment purposes:

In the context of a functional, therapeutic relationship or series of such relationships, irremediability for MD-SUMC MAiD assessment purposes exists in circumstances where:

- 1) *a capable person (requestor) has tried, as available and accessible to them, multimodal, health care treatments and interventions falling within the scope of the relevant, existing standard-of-care for the person's qualifying mental health disorder(s)* which, over a prolonged period of time, i.e., years, have been ineffective in adequately relieving the person's suffering and/or which have resulted in side effects and/or complications that are unacceptable to the person, and*
- 2) *other available, appropriate treatments and interventions for the person's health condition(s), of which the person has been fully informed, have been declined by the person after being given meaningful, collaborative consideration by the person and their attending clinician(s).*

* In order to meet the irremediability MAiD eligibility criterion in MD-SUMC circumstances, the requestor is not required to have tried and failed all of the treatments and interventions that fall within the scope of the relevant, existing standard-of-care for the person's underlying mental health disorder(s).

Notes:

1. An independent psychiatrist in their role as a MAiD assessor determines (through an in-person or virtual assessment of the requestor):
 - a) the nature and scope of the treatments and interventions that fall within the relevant, existing standard-of-care in the particular, clinical and sociocultural circumstances of the person; b) the adequacy of the period of time (years) that the person has been under active treatment for their suffering; and 3) the adequacy of the lengths of time of the trials of treatments and interventions. The independent psychiatrist may consult, as appropriate and at their professional discretion, with a sub-specialist -/ -special-interest-psychiatrist who has advanced knowledge about, and experience in the treatment of, the mental health disorder that is giving rise to the person's profound suffering.
2. When these described MD-SUMC circumstances exist, the person is deemed to have an incurable illness, disease or disability, and to be in an advanced state of irreversible decline in functional capacity. Further, their enduring suffering cannot be relieved under conditions that they consider acceptable.

This practical description effectively captures all the key elements of an optimal assessment of irremediability for MD-SUMC assessment purposes. As such, it is intended as guidance for those directly engaged in performing MD-SUMC assessments and P/T professional regulatory authorities that develop relevant MAiD practice standards and policies.

CONCLUSION

In this critical commentary, an ethics lens is applied to the interpretation of irremediability for MAiD assessment purposes in circumstances where the sole-underlying medical condition(s) is a mental health disorder(s). Arising from exploration and analysis of relevant ethics elements and considerations, a practical description of irremediability in the MD-SUMC context is proposed for intended use as guidance by Canadian mental health care clinicians, MAiD assessors and providers, and provincial/territorial professional regulatory authorities.

Reçu/Received: 28/05/2022

Conflits d'intérêts

Aucun à déclarer

Publié/Published: 9/12/2022

Conflicts of Interest

None to declare

Édition/Editors: Aliya Affdal

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