EXPERTS WEIGH IN: EXAMINING THE DEBATE ABOUT MEDICAL ASSISTANCE IN DYING (MAID) FOR MENTAL ILLNESS IN CANADA

by

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ABSTRACT

Despite its legalization, Medical Assistance in Dying (MAiD) has become one of Canada’s most controversial socio-political issues. The prospect of implementing MAiD for persons with mental illness as their sole underlying medical condition (MI-SUMC) has generated a particularly polarizing discussion among experts, whose discourses influence public opinion and policy formation. Using ethnographic content analysis, this thesis examines the arguments deployed by experts and the construction of MAiD MI-SUMC across news articles, commentaries, and position statements. This study finds that the discourses emerging from the expert debate can be categorized into two overarching frames – legal rights and clinical ethics –which function collectively to reflect broader tensions around mental illness, and ultimately underscore a larger call for a reassessment of mental healthcare in Canada. Across my dataset, some experts constructed the practice as promoting human rights and improving psychiatric care, while others depicted it as an ableist policy that conflicts with the goals of psychiatry. As experts continue to weigh in on this divisive issue, this thesis demonstrates the power of the debate to have a much wider impact than on MAiD policy itself, by influencing the cultural conversation around mental illness and psychiatry.

LIST OF ABBREVIATIONS USED

CAMH	Centre for Addiction and Mental Health
CASP	Canadian Association for Suicide Prevention
CMHA	Canadian Mental Health Association
CPA	Canadian Psychiatric Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
DWDC	Dying with Dignity Canada
EAS	Euthanasia and Assisted Suicide
ECA	Ethnographic Content Analysis
MAiD	Medical Assistance in Dying
MAiD MI-SUMC	MAiD where a Mental Illness is the Sole Underlying Medical Condition
MMS	MAiD MI-SUMC
RFND	Reasonably Foreseeable Natural Death
QCA	Quantitative Content Analysis
VPS	Vulnerable Persons Standard

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CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1 The MAiD Debate

Assisted dying has emerged as one of the most divisive social and political issues in recent decades, mobilising numerous actors and several legal challenges in North America and Europe (Gandsman & Burnier, 2014). In 2015, a landmark decision by the Supreme Court of Canada (SCC) led to the decriminalization of assisted dying, referred to as Medical Assistance in Dying (MAiD) (Downie, 2022). From then on, eligible adults could legally request and access medical assistance to die, thus transforming the landscape of death and dying in Canada.[1] Legalization, however, did not resolve the contentiousness surrounding the notion of assisted dying, as evidenced by the ongoing and impassioned debate about the evolution of MAiD legislation (Pesut et al., 2021). At the core of the current debate is eligibility criteria, and whether access to MAiD should be available to Canadians suffering solely from mental illness.[2]

Consider the following scenario: An 82-year-old person suffers from severe mental illness including depression, post-traumatic stress disorder and anxiety disorder. They were first diagnosed 30 years ago and have since been admitted to seven psychiatric hospitals. They have also undergone every available intervention, biomedical and natural remedies alike. To this day, no treatment has had any positive effect, and they have attempted to die by suicide twice. They want the option to be assessed for assisted dying in the hope of permanently alleviating their suffering. This case is not fictitious. This is the story of

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[1] It is important to note that shortly prior to federal law reform, lawful MAiD first came to Canada in Québec (Downie, 2022). This was made possible because both the administration of the justice system and delivery of health services rests with the provinces and territories (see Downie, 2022 for a more detailed explanation).

[2] Other, equally contentious, aspects of MAiD policy are being debated concurrently, including the issues of advance requests and requests from mature minors. However, this thesis focuses explicitly on the issue of MAiD in the case of mental illness as the sole underlying medical condition.

Canadian author, journalist, and outspoken MAiD advocate, John Scully (see Dobec & Scully, 2022; Fraser, 2023; Scully, 2020), and it is situations like Scully's that are regularly, and fiercely, debated in public, academic, and parliamentary discourses.

Broadly speaking, proponents for the inclusion of mental illness into MAiD eligibility address the following key issues: respect for autonomy; quality of life; ending pain and suffering; reducing distress caused by suicide attempts; mitigating discrimination and stigma; and maintaining dignity (Bahji & Delva, 2021; Downie & Schüklenk, 2021; Nicolini et al., 2020; Plaisance et al., 2022). Conversely, opponents often employ notions of vulnerability, the sanctity of life, (in)capacity, suicidality, and treatment gaps to argue for the continued exclusion of mental illness from MAiD eligibility (Blikshavn et al., 2017; Nicolini et al., 2020; Van de Walle & Kuby, 2022). Amidst the wide array of actors involved in discussions about MAiD, experts, including informed stakeholders, appear to play a significant role in constructing the framework within which MAiD where mental illness is the sole underlying condition (MAiD MI-SUMC) is debated.

Expert advice is critical for policymaking in the modern state (Löblova, 2018). In health policy especially, experts have played an important role following the rise of evidence-based medicine and evidence-informed policy (Löblova, 2018). According to Adekola et al. (2019), experts are of particular importance "where there is a weak evidential base and where multiple interpretations, power dynamics and values are brought to bear on public health risk issues" (p. 1295), which is true of MAiD MI-SUMC (MMS). In Canada, expert witnesses from a range of fields have been called upon to provide key information and present different sides of the debate to Parliament, answering questions based on their experiential knowledge. They have also been commissioned to produce reports on the topic (see Council of Canadian Academies, 2018; Health Canada, 2022b), representing what sociologist Meling (2022) has described as an "outsourcing of normative power" (p. 657) to experts. Therefore, I argue that experts hold considerable normative and practical power to define the boundaries of the MMS debate, inform the discourses that emerge and circulate, and ultimately influence the progression of Canadian legislation.

As Parliament deliberates over evidence and expert testimony, news stories are published weekly with reporting ranging from positive anecdotes and heartfelt testimonials to Nazi analogies and murder accusations. When designing this study, I anticipated that death and mental illness would emerge as two separate objects of analysis; that expert discourses would reveal something of conceptualizations and societal anxieties about death and dying, and of mental illness. However, as this thesis will show, the documents that I reviewed revealed a remarkable absence of death talk in the debate. Instead, tensions around mental illness and mental healthcare in Canada dominated expert dialogue. As per Roberts (2005), "bodies of psychiatric knowledge are thoroughly enmeshed within the history of the culture and the society in which they occur and therefore are inextricably bound to the political concerns, norms and values of that culture and society" (p. 37). Thus, I contend that the discourses emerging from these documents – about MAiD for mental illness – are socially significant, and that the way in which experts frame and debate MMS both shapes and reflects understandings of mental illness and psychiatry.

In this thesis, I wade into the controversy to examine the various arguments deployed by experts. I employ Altheide and Schneider's (2013) ethnographic content analysis (ECA) to explore the discursive construction of the MMS debate. I do not seek to answer the moral question of whether assisted dying for mental illness is 'right' or 'wrong' nor do I intend to describe which experts, whether it be doctors, lawyers, or otherwise, deploy which arguments or in which communication medium they appear. Instead, I hope to illuminate the dominant discourses driving the debate and analyze how experts frame MMS with the aim of elucidating some of the values and assumptions that underlie expert argumentation. Moreover, I consider what the dominant framings that emerged from my study – legal rights and clinical ethics – reveal about understandings of mental illness and the status of mental healthcare in Canada. Although I recognize that my analysis is limited by my choice not to investigate who said what and where, I see this study as a point of departure and as the beginning of my venture into the realm of assisted dying research.

While there is no shortage of social scientific literature on death, suicide, and mental illness, anthropological perspectives on assisted dying are limited, and Canadian anthropological perspectives are more limited still. Accordingly, throughout this thesis I draw on ideas from sociology, philosophy, communications, law, bioethics, and other disciplines. Nevertheless, my research is consistent with a socio-anthropological approach to assisted dying which seeks to locate the practice, and associated discourses, within its social and cultural context (Young, 2020).

1.1.1 Canada's Legislative Journey

The legalization of assisted dying in Canada materialized over several decades (Frolic & Oliphant, 2022). In 1993, the SCC dismissed the first federal right to die appeal by Sue Rodriguez, a woman living with amyotrophic lateral sclerosis (ALS), who challenged the validity of the Criminal Code prohibition on assisted dying (Downie, 2022). From then on, various attempts to decriminalize assisted dying went unsuccessful, but nevertheless initiated a polarizing national conversation around assisted death. Decades later in 2015, a legal case originating in British Columbia (*Carter v. Canada*) ended with the SCC ruling that the ban on assisted dying was unconstitutional under the Canadian Charter of Rights and Freedoms (Downie, 2022). Following this historic ruling, the federal Parliament passed Bill C-14 to bring the Criminal Code in line with the Charter, making MAiD a legally accessible option for eligible Canadians (Frolic & Oliphant, 2022). The amendments to the Criminal Code provided the criteria through which MAiD could be provided (Frolic & Oliphant, 2022), as described in Table 1. However, the new law was challenged almost immediately by assisted dying advocates and legal scholars as being too restrictive and deviating from some of the requirements set out in the *Carter* decision.

Table 1: MAiD Eligibility Criteria
Sources: [Frolic & Oliphant, 2022; Government of Canada, 2023]

(1)	**A person may be eligible for MAiD only if they meet all of the following criteria:**
a)	they are eligible for health services funded by a province or territory, or the federal government;
a)	they are at least 18 years old and mentally competent (i.e., capable of making health care decisions for themselves);
b)	they have a grievous and irremediable medical condition;
c)	they have made a voluntary request for MAiD that is not the result of outside influence or pressure; and
d)	they give informed consent to receive MAiD
(2)	**A person has a grievous and irremediable medical condition if they meet all of the following criteria:**
a)	they have a serious illness, disease or disability*;
b)	they are in an advanced state of irreversible decline;
c)	they are experiencing unbearable physical or mental suffering from the illness, disease, disability, or state of decline that cannot be relieved under conditions that they consider acceptable; and
d)	their natural death has become reasonably foreseeable, considering all of their medical circumstances**

* Excluding a mental illness until March 17, 2024.
**This criterion was removed in the 2021 amendments to Canadian law governing MAiD through the passing of Bill C-7.

In 2019, two plaintiffs successfully appealed to the Supreme Court of Québec to have the reasonably foreseeable natural death (RFND) eligibility requirement removed (Frolic & Oliphant, 2022). After a period of public and parliamentary debate (2020-2021), the Government amended the relevant sections of the Criminal Code through the passing of Bill C-7[3] and expanded MAiD eligibility to individuals whose death is not reasonably foreseeable (Frolic & Oliphant, 2022). As a result, MAiD now operates on a two-track system. One track for those with a RFND and a second, with additional safeguards such as a minimum assessment period of 90 days and a requirement to ensure that patients have been informed of alternative means to relieve suffering, for those who meet all other criteria, but who will not die of a natural death in the foreseeable future (Downie, 2021; Frolic & Oliphant, 2022). In 2021, MAiD deaths accounted for 3.3% of all Canadian deaths (Health Canada, 2022a). Most of those deaths were patients with a RFND (i.e., track one); only 2.2% of the total number of MAiD provisions were identified as non-RFND (i.e., track two) patients (Health Canada, 2022a).

Recognizing that persons with a mental illness as their sole underlying medical condition (MI-SUMC) could qualify for MAiD through track two, a temporary two-year exclusion was granted to provide additional time to study how assisted dying can be safely provided to this population, to assess expert recommendations and to ensure that appropriate safeguards would be put in place prior to implementation (Frolic & Oliphant, 2022; Government of Canada, 2023). The exclusion was meant to be automatically repealed in March 2023, however, in February 2023, the Government introduced

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[3] Bill C-7, An Act to amend the Criminal Code (Medical Assistance in Dying) was introduced by the Government of Canada on February 24, 2020, in response to the Superior Court of Quebec *Truchon* decision which declared unconstitutional the “reasonable foreseeability of natural death” eligibility criterion (Government of Canada, 2023).

legislation (Bill C-39) to prolong the temporary ban for an additional year (Government of Canada, 2023). At the time of writing, heated debates about whether people suffering solely from mental illness should have access to MAiD persist in public and professional spheres, with advocates of the practice insisting that we have moved on from the question of *if* MAID for mental illness will be made available, to *how* requests and assessments will be managed (Downie & Schüklenk, 2021). Unless the Government introduces additional legislative changes, the ban will be lifted on March 17th, 2024, and Canada will join a handful of countries – Belgium, the Netherlands, Luxembourg, and Switzerland – who do not exclude adults suffering solely from psychiatric conditions from the option of assisted death.

Despite what the popular language of "expansion" and "extension" might suggest, it is important to note that Canadians suffering solely from mental illness were not explicitly excluded from accessing MAiD prior to the passage of Bill C-7. Although the legislative language was vague, legal scholars Downie and Chandler (2018) argued that a mental illness was not automatically disqualifying if a patient met all other eligibility criteria. In fact, an Alberta woman with a mental disorder (severe conversion disorder[4]) as her sole underlying condition, identified as E.F. by the court, succeeded in receiving an assisted death in 2016 (Downie & Schüklenk, 2021; Health Canada, 2022b). Despite her illness being rooted in a psychiatric condition, E.F.'s assisted death was approved during the 16-month period between the *Carter* decision and the passing of Bill C-14, where

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[4] Severe conversion disorder, also known as functional neurological symptom disorder, is a psychiatric disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is characterized by signs and symptoms affecting sensory or motor function, which is often explained as a physical manifestation of psychological distress (Fobian & Elliott, 2019; Peeling & Muzio, 2023). E.F was diagnosed with the disorder nine years prior to her assisted death (Health Canada, 2022b). During this time, she tried various treatments and was seen by several psychiatrists, none of which could help alleviate her symptoms or her suffering (Health Canada, 2022b).

“persons who wished to receive MAiD were permitted to seek judicial authorization to do so if they met the eligibility set out in *Carter”* (Health Canada, 2022b, p. 23). Furthermore, the current law does not prevent those with comorbid physical and mental illness – ALS and depression for example – from receiving MAiD if they otherwise meet eligibility criteria (Health Canada, 2022b). All things considered, should MMS become legal, Canada is poised to host one of the most permissive assisted dying regimes in the world.

1.1.2 The Logistics of MAiD

While the criminal code is under the jurisdiction of Parliament, health care delivery is a provincial responsibility (Downie, 2022; Government of Canada, 2023). Because provincial and territorial governments are responsible for the regulation and provision of MAiD, policies and procedures may vary by province/territory (Government of Canada, 2023). Nevertheless, a similar process is followed across the country with the aim of ensuring that the service is carried out in a way that protects Canadians from abuse and/or misuse (Government of Canada, 2023).

Generally, to make a formal request for MAiD, an individual must submit a request in writing that is signed and dated before one independent witness (Dying with Dignity Canada [DWDC], 2023; Government of Canada, 2023). Once the request is received, two independent assessors (physicians and/or nurse practitioners) must confirm that the person meets all eligibility requirements (DWDC, 2023). If the person’s natural death is not reasonably foreseeable (i.e., if they fall into track two), one of the two practitioners confirming eligibility must have or consult expertise in the condition that is causing the person’s intolerable suffering (Government of Canada, 2023). If a track one patient is deemed eligible for MAiD, they may choose to schedule their assisted death for any date

(Government of Canada, 2023). For those in the track two programme however, there must be a minimum of ninety days from the date of approval to the date of MAiD provision (Government of Canada, 2023). Immediately before MAiD is provided – which will typically occur at the person's home or a medical institution – the individual must be given the opportunity to withdraw consent and affirm that they consent to receive MAiD, though exceptions to this requirement are sometimes made for track one cases (see Government of Canada, 2023 for more information about waivers of final consent).

Physicians or nurse practitioners can be involved in MAiD as assessors and/or providers (Government of Canada, 2023). Federal law does not compel practitioners to participate in MAiD (Government of Canada, 2023). However, some provincial regulatory authorities have issued guidelines that strongly encourage or require practitioners who are unwilling or unable to participate in MAiD to refer their patients to other institutions or providers who can (DWDC, 2023). For instance, objecting practitioners in Ontario must make what is termed an "effective referral" to a practitioner or agency that is willing and able to facilitate assisted dying requests (DWDC, 2023).

The cost of offering MAiD is split into three components: 1) time billed by practitioners to do MAiD-related work (e.g., assessments, paperwork, administering drugs), 2) the cost of the drugs used to induce death, and 3) the cost of oversight in some provinces (Bernier et al., 2020). Unlike the high costs incurred by patients to access assisted dying in the United States (Buchbinder, 2021), much of the cost in Canada is borne by provincial governments (Bernier et al., 2020; Government of Canada, 2023). In a 2020 report commissioned by a Senator to estimate the financial cost of Bill C-7, Bernier et al. (2020) estimated that the total cost of a completed MAiD case would be $2,327,32 while an assessed case would cost $733.87. They concluded that expanding access to MAiD would ultimately result in a net reduction in health care costs for governments (Bernier et al., 2020). Similarly, in a cost analysis of MAiD in Canada, Trachtenberg and Manns (2017) determined that providing MAiD would result in substantial savings by reducing annual health care spending across Canada by between 34.7 and 138.8 million dollars. Concerns that the potential for reduced health care costs might provide impetus to broaden eligibility criteria can be gleaned from some of the arguments presented against MMS (see section 3.3.2 An Ableist Amendment), though I do not explicitly address this issue in this thesis.

1.1.3 A Note on Terminology

Terminology is a main point of contention in the assisted dying debate. The words used to denote what is currently known in Canada as medical assistance in dying (MAiD) vary by jurisdiction and have historically been marked by ambiguity, euphemism, and misunderstanding (Macauley, 2019; Mroz et al., 2021). Previous studies and scholars have explored how language plays a role in the assisted dying debate and have argued that the language used to describe the practice is not neutral, but rather is imbued with power, reflects various ideological standpoints, and can have lingering social effects (Kobewka, 2013; Macauley, 2019; Manns, 2017; Quill & Battin, 2022). Across my dataset, experts used a variety of terms to describe the practice. Thus, for the sake of clarity, I will discuss my use of particular terms over others and define their meanings.

Throughout this thesis I use the terms ‘medical assistance in dying (MAiD)’, ‘assisted dying’ and ‘aid in dying’ interchangeably to encompass physician-administered death (widely known as euthanasia) and patient-administered death (widely known as assisted suicide) (Koksvik et al., 2020). Both physician-administered MAiD – in which a physician or nurse practitioner intentionally ends a person's life through the administration of lethal pharmaceuticals – and patient-administered MAiD – in which a physician or nurse practitioner helps a person terminate their life by prescribing the drugs for self-administration – are permitted under Canadian law, though the latter is much less common; it was used in fewer than seven MAiD deaths in 2021 (Health Canada, 2022a).

Government commissioned reports and parliamentary debates often use "MAiD MI-SUMC" when referring to MAiD for patients whose sole underlying condition is a mental illness in the Canadian context. However, for readability, I've chosen to use the acronym MMS throughout this thesis. When referring to the practice outside of Canada, I use 'psychiatric euthanasia or assisted suicide (psychiatric EAS)', in line with the language used by Kim et al. (2016) in their benchmark study of the practice in the Netherlands. The abovementioned terms all refer to situations whereby a patient who meets legal eligibility criteria *voluntarily* consents to the active ending of their life.

Terminological confusion extends beyond the terms used to describe the practice itself to the terms used to describe the medical conditions which may render a patient eligible for MAiD. Bill C-7 and associated materials (e.g., legislative background and Charter Statements) use the term "mental illness". However, which conditions are included by the expression "mental illness" remains undefined in the legislation. As such, those involved in the production of the most recent Expert Panel Report (Health Canada, 2022b) raised concerns that referring to "mental illness" would create confusion around to whom the panel's advice applies. The panel chose to use "mental disorder" because this is the term used in both major diagnostic classification schemes relied upon in Canadian psychiatric practice (i.e., the Diagnostic and Statistical Manual of Mental Disorders [DSM] and International Classification of Diseases) (Health Canada, 2022b). Nevertheless, both terms – mental illness and mental disorder – are regularly used in expert testimony and Parliamentary debates. Following these discursive norms, I use both terms throughout this thesis. However, recognizing that the term used can promote a different understanding of the nature of the condition, I use "mental illness" more broadly, reserving the term "mental disorder" for DSM diagnoses.

1.2 Research Questions and Objectives

The purpose of this research is to describe and analyze expert discourses regarding the possibility of MAiD for persons in Canada with mental illness as a sole underlying condition (MMS). My primary research question is: How is MMS constructed in the expert debate? In addressing this question, I seek to gain insight into what the discourses emerging from the debate reveal about contemporary understandings of mental illness. By exploring the themes, frames, and discourses that emerge from expert argumentation, I also aim to elicit the values and assumptions that underlie experts' ideological standpoints. Ultimately, this study aims to provide a deeper understanding of the MMS debate and conceptualizations of mental illness in Canada by exploring the perspectives and reasoning of experts immersed in the dialogue on assisted dying.

1.3 Literature Review

In this section, I describe some of the relevant literature on death and dying, mental illness, assisted death, and the methodological framework through which I approach my research. First, I describe some significant changes to the Canadian death system that have contributed to the emergence of assisted dying as a legal right. Second, I provide a brief historical overview to outline the shifts and trends in mental illness and psychiatry in Canada, including the current state of mental health services. Third, I review the extant literature on assisted dying for persons with mental illness as a sole underlying condition. Fourth, I explore anthropology and sociology's contributions to the study of assisted dying. Lastly, I explain how notions of discourse and framing inform my analysis.

I rely primarily on literature emerging from a 'Western'[5] context as this is where a lot of the anthropology of death and dying and assisted dying literatures are produced and because the focus of my study is Canada. Indeed, most of the countries where the practice of assisted dying has been legalized are situated in Europe and North America (Mroz et al., 2021). Nevertheless, the idea of dying well and assisted dying in its various forms has been debated in 'Eastern' philosophies for millennia (see Ping-Cheung, 1999; Young, 1994). Non-Western countries have also played a central role in the development of psychiatry and remain important players in global mental health networks (see Heaton, 2013). As such, echoing Young (2020), I recognize the limitation that the sources I draw on to inform my investigation into MMS are mostly embedded within Western epistemology and acknowledge that I, myself, am situated within and influenced by prevailing values and norms of a typically Western worldview.

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[5] Despite challenges to the notion of an East-West divide in the social sciences (see Hendry & Wong, 2009), I refer to the West throughout this literature review to denote European and North American jurisdictions because this dichotomy is used in much of the literature that informs this review (see Aries 1974; Krippner & Kasian, 2009; Timmermans, 2005 for example).

1.3.1 Evolving Death Systems

The social and legal sanctioning of assisted dying can be thought of as marking shifting ideas about the social expectations, rules, norms, and symbols that orient encounters with dying, all of which form part of what Kastenbaum (1977) termed a culture's "death system" (Richards & Krawczyk, 2021). All societies have death systems, that is, "affective systems constituted through the myriad social processes that teach us what to think and feel about death and dying, and what to do about it" (Richards & Krawczyk, 2021, p. 61). Western societies' death systems have historically been characterized as 'death denying', fuelled by a taboo around talking about death (Aries, 1974; Gorer, 1955) and biomedicine's technological imperative in the care of dying persons (Krippner & Kasian, 2009). The public debate on MAiD in Canada, however, suggests a growing willingness to discuss death. Although the topic of death itself was overshadowed by mental illness in the documents I reviewed, it is nonetheless important for context to highlight certain changes to Canada's death system that can be attributed to the emergence of assisted dying as a desirable legal right.

Starting in the mid-twentieth century, dying in Western societies was gradually transformed from an existential moment governed by religion into a technical event managed by biomedicine (Karsoho et al., 2016; Lavi, 2005). This process can best be described by the concept of "medicalisation". Medicalisation is a process by which human problems come to be defined and treated as medical problems (Clark, 2014; Conrad, 2005). Driven in part by changes in medical knowledge and organization, modern medicine's mastery over death is evidenced by the fact that most people die in medical facilities (Koksvik et al., 2020) and that dying is increasingly preceded by clinical negotiation about the use of biomedical technologies and efforts to prolong life (Karsoho et al., 2016; Kaufman, 2005). Timmermans (2005) attributes medicine's continuing dominance over dying to the "death brokering" (p. 992) capabilities of physicians – that is, the authority ascribed to medical practitioners by the public to render death culturally appropriate and socially meaningful. This is not to say, however, that the medicalisation of dying has progressed without contestation or pushback (Lavi, 2005; Timmermans, 2005).

Towards the latter half of the twentieth century, right-to-die activists were among the strongest opponents to escalating hospitalization and the use of life -prolonging technologies (e.g., mechanical respiration and artificial nutrition) at the end of life[6] (Richards, 2017; Timmermans, 2005). Some scholars thus suggest that a right-to-die movement first emerged in the 1970s as a rejection of medical interference in death (Kastenbaum & Moreman, 2018; Timmermans, 2005). Indeed, medicine's technological imperative has been explicitly linked to the denial of death by those who contrast curative medicine and assistance in dying, characterizing the former as death denying and the latter as a return to 'natural' dying and death acceptance (Gandsman, 2018; Kubler-Ross, 1969; Norwood, 2018). Sociologist Shai Lavi (2005) proposes an alternate perspective on the relationship between medicalisation and assisted dying, arguing that demands for a demedicalised death date back even further to the 1800s and challenge a much broader "Enlightenment desire for a technical mastery over death and a concomitant loss of 'art' of dying" (Richards, 2017, p. 350). Paradoxically, although there are some models of assisted dying in which medical aspects are challenged or diminished (Ost, 2010), in most

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[6] Another prominent opponent of the medicalisation of dying was the hospice/palliative care system (Koksvik et al., 2020; Timmermans, 2005). For more information on the relationship between palliative care and assisted dying, see Freeman et al. (2021) or Gerson et al. (2021).

jurisdictions, the practice has been introduced within a medicalised framework and equated with a ‘good death’.

The notion of a ‘good death’ became a key concept in death studies partly as a reaction to the increasing medicalisation of life’s end (Green, 2012) and has been addressed extensively in a body of social scientific literature dedicated to exploring various facets of a ‘good death’ (Aries, 1974; Green, 2012; Seale, 1998; Walter, 2003). At its most basic level, a good death is a culturally acceptable way of dying (Timmermans, 2005) or a successful death (Meier et al., 2016). The idea of dying well dates back to the Middle Ages where a good death, per the popular thirteenth-century Christian manuals known as *Ars Moriendi*, was one that was rooted in religion through final rites and the repenting of sin (Green, 2012; Lavi, 2005). An essential element in the ‘good death’ discourse is the juxtaposition of ‘good’ against ‘bad’ modes of dying. However, modern Euro-colonial notions of what constitutes ‘good’ or ‘bad’ death have shifted markedly.

Although cultural conceptualizations of death vary, the literature suggests that expectations of individualism and choice emerging alongside neoliberalism have shaped Western understandings of ‘good’ versus ‘bad’ death. Archetypal examples of bad death include non-assisted suicide, homicide, or death by tragic accident (Richards, 2017). Among the range of criteria identified to achieve a good death, social scientists have found that contemporary Western understandings accommodate patient autonomy and consumer choice and emphasize freedom from meaningless pain and suffering (Richards & Krawczyk, 2021), naturalness (Gandsman, 2018), control (Buchbinder, 2021; Walter, 2003), and preparation (Koksvik et al., 2020). Assisted dying is often touted by proponents as fulfilling the criteria for a good death. In fact, the word ‘euthanasia’ itself derives from the Greek words ‘eu’ (good) and ‘thanatos’ (death) (van Hooff, 2004). Related neoliberal ideals - autonomy and dignity - have also informed another relevant distinction in contemporary dying.

Since the 1980s, scholars have drawn attention to the distinction between biological or physical death and ‘social death’. Whereas biological death occurs with the total cessation of vital physical functions of the body (Borgstrom, 2017), social death – which has been widely investigated in the social sciences (Borgstrom, 2017; Norwood, 2020; Patterson, 1982; Seale, 1998) – can be described as a “series of social losses” (Norwood, 2020, p. 4), such as the loss of independence or mobility, that combine to disconnect a person from social life such that while they may be biologically alive, they are deceased from a social perspective (Norwood, 2020; Seale, 1998).

In their ethnographic study of dying in Germany, Menzfeld (2018) found that social embeddedness influences the quality of dying, with more socially alive individuals having better deaths compared to those who are socially isolated. Likewise, recent ethnographic studies demonstrate that the threat of social death – life with limited social engagements and the loss of sociality – is a central motivating feature in assisted dying requests (Buchbinder, 2021; Norwood, 2020; Stavrianakis, 2020). Using MAiD, patients can avoid a situation in which social death precedes biological death, thus enabling them to reaffirm their identity, remain recognizable to their loved ones and script the final memories that they leave behind (Buchbinder, 2021; Norwood, 2020). For example, in a 2009 study of euthanasia in the Netherlands, Norwood (2020) engaged with a cancer patient who tracked their sociality through their ability to participate in creative activities. When they could no longer engage meaningfully in their social environment by painting or writing haikus, they chose an assisted death. That social disruptions might be seen to be equally, if not more powerfully motivating than biological health conditions themselves has enormous consequences for evolving MAiD debates, especially when one considers the mounting evidence about the reciprocal relationship between mental health and social factors, including relationships, housing, employment and so on (Alegría et al., 2018).

The medicalisation of death, alongside shifting understandings of a good death, increasing individualism and growing recognition of social death underpin many of the arguments in favor of MAiD. Thus, it is fair to surmise that the changes outlined above, to Canada's death system, have culminated in the emergence of assisted dying as both a legal right and an increasingly normalized medical practice. I argue that MAiD would not be possible without such evolution in the history of the ways of approaching and conceptualizing death and dying. These changes have also played a role in the evolution of assisted dying discourses, to the point that the option of assisted dying for mental illness has become a conceivable possibility in Canada.

1.3.2 Mental Illness in Canada

Understandings of mental illness and corresponding treatment modalities have shifted markedly in the West over the past century. As the medical branch concerned with the causes, diagnosis, and treatment of mental illness, psychiatry shapes both how we know, talk about, and intervene upon mental illness (Rose, 2018). The discipline, however, is characterized by distinct ontological problems and contested conditions, and has long maintained a marginal position in the hierarchy of medical specialties (Fabrega, 1993; Rosenberg, 2006). Plagued by "recurrent status anxiety" (Rosenberg, 2006, p. 411), psychiatry's apparent inferiority is largely due to its inability to clearly define the boundaries of what counts as mental illness (Horwitz, 2011; Jutel, 2014; Rosenberg, 2006). Since the mid 1960s, the discipline has been divided by advocates of conflicting ontologies (Helén, 2007).

Since the publication of the Flexner Report[7] in 1910, there has been a tendency to favor biomedical explanations over other approaches in psychiatry (Duffy 2012; Stahnisch et al 2011). Indeed, since the release of the DSM-III, the dominant psychoanalytical framework in psychiatry was replaced with a fervor for biological explanations (Horwitz, 2002; Kleinman, 1988). Those in favor of the paradigm shift argued that a biomedical model of mental illness would promote the conception of mental illness as a disease like any other, offering the promise of legitimacy, destigmatization, and improved treatment outcomes (Horwitz, 2011). However, despite decades of neurobiological research, most mental disorders lack a pathophysiological model and the efficacy of many drug treatments remains unclear (Rose, 2018). For instance, an umbrella review published last year suggests that there is no convincing evidence that depression is associated with, or caused by, lower serotonin (Moncrieff et al., 2022). The authors of the review thus concluded that the huge research effort based on the serotonin hypothesis – including the widely prescribed Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants - has not produced persuasive evidence of a biochemical basis to depression (Moncrieff et al., 2022). Nevertheless, psychiatric taxonomy and treatment modalities are increasingly driven by

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[7] The Flexner Report was a critical review of American/Canadian medical education written by Alexander Flexner in 1910 (Duffy, 2011). As per Duffy (2011), the report embraced scientific knowledge as the defining ethos of modern medicine and "transformed the nature and process of medical education in America with a resulting elimination of proprietary schools and the establishment of the biomedical model as the gold standard of medical training" (p. 269).

biomedical models of illness which attribute mental disorder to dysfunction in the brain. Despite its position as the dominant paradigm, the biopsychiatric model is highly contested both within and outside the discipline of psychiatry.

The almost exclusively biogenetic framework for understanding mental illness, has been widely critiqued as grossly oversimplifying a complex human problem. For instance, Horwitz (2002) argues that by failing to consider external factors, modern psychiatry has lost sight of the distinction between normal reactions to social stressors and mental disorders. Critics also argue that not only does the move to a primarily biological understanding of mental illness neglect the social, cultural, and environmental dimensions of suffering, thus fracturing the experience of mental illness, but also imposes and reinforces colonial Western cultural hegemony, serving the interests of the profession and the pharmaceutical industry rather than the patient (Horwitz, 2002; Jutel, 2014; Kirmayer et al., 2015; Malla et al., 2015). Other scholars have gone as far as to question if caring for patients with psychiatric suffering even falls within the purview of medicine at all (Perreault et al., 2019; Rose, 2018). Rose (2018), for example, suggests that psychiatry should break its associations with biomedicine entirely as it relies on methodologies (such as genetic testing and symptom checklists) that are unsuited and thus unable to fully capture a patients experience of mental illness. Most social science scholars, however, advocate for more holistic models of health and illness that integrate mind, body, and society (Bendelow, 2010; Kirmayer et al., 2015). Biopsychosocial (Bendelow, 2010) or ecosocial (Kirmayer et al., 2015) models align with a more externalist view of mental illness, which holds that a person’s mental health – or illness – depends on facts about their social, material, and cultural environment and not just upon facts about their brain (Glackin et al., 2021). In addition to struggling with discordant models of mental illness, psychiatry is plagued by problems of reliability and validity.

Given the lack of objective diagnostic tests for mental disorders, the issue of reliability has posed challenges to psychiatry for decades (Beck, 1962; Hyman, 2010; Spitzer & Fleiss, 1974). Despite claims that the DSM-III has significantly reduced problems of reliability by introducing operationalized diagnostic criteria, some researchers suggest that that "reliability of the DSM is frequently overestimated" (Vanheule et al., 2014, p. 314). For example, in their review of literature on the concept of reliability of psychiatric diagnosis, Aboraya et al. (2006) state that "a review of the chart of inpatient admissions of a single patient will reveal multiple different diagnoses for the same patient" (p. 44), suggesting low interrater reliability among practicing clinicians. It is easy to imagine that poor interrater reliability could have serious implications for MMS when it comes to eligibility assessments, as two independent clinicians might disagree over diagnoses. Moreover, it has been argued that prioritizing reliability has come at a cost to validity (Horwitz, 2002; Hyman, 2010).

The validity of psychiatric categories remains uncertain and has been challenged extensively. According to Whooley (2016), "validity holds nature or reality as its referent. In nosology, valid diagnoses reflect 'natural kinds', accurately representing the reality of pathological processes, via theories about the underlying causes of disease entities" (p. 38). However, as noted earlier, an understanding of the causal mechanism of mental disorders upon which validity depends is notably absent (Whooley, 2016). In addition to disagreement about whether mental disorders, like depression and schizophrenia, align with their DSM definitions, "scholars have been particularly critical of the rapid proliferation of diagnostic labels and the expanding list of behaviors that are perceived as pathological" (Halpin, 2022, p. 512). For instance, some scholars hold the view that ever-increasing diagnostic categories pathologize normal experiences of living (Horwitz, 2002; Szasz, 1961) or that DSM expansion is driven by the corporate interests of large pharmaceutical companies (Conrad, 2005; Jutel, 2014). Indeed, one of the most controversial issues in evaluating mental disorders are whether such disorders even exist. The issue of validity and whether these disorders are "real" or not is important to ongoing MAiD debates and helps to contextualize some of the arguments presented against MMS.

In addition to being mocked for its inability to clearly demarcate and diagnose mental illness (Horwitz, 2011), psychiatry has long had a rather sinister reputation due to its involvement in various social atrocities. The profession has been known to subject individuals to terror, torture, and homicide under the guise of psychiatric treatment (Kleinman, 1988; Rose, 2018). Shackles, cages, electric shocks, insulin comas, and drilling holes in patients' skulls (lobotomy) are just some examples of the physical treatment that psychiatric patients endured (LeFrançois et al., 2013). The use of psychiatric reasoning to justify abuse is particularly evident in the history of eugenics, forced sterilization, and mental asylums (Rose, 2018). In his highly influential critique of psychiatry, *Asylums*, sociologist Erving Goffman compared mental hospitals to concentration camps and prisons. Other prominent scholars depicted psychiatrization as an instrument of disciplinary control and oppression (Foucault, 1965; Szasz, 2007). Beginning in the 1960s, leading anti-psychiatrists and a variety of feminist and sociological critics of psychiatric authority who considered psychiatry to be an institution of social control condemned the extensive abuse that was taking place within treatment facilities (Busfield, 2014).

Subsequently, an era of patient empowerment emerged, driven by notions of autonomy and freedom (Moncrieff, 2014).

Since the 1960s and the first wave of antipsychiatry, patient liberation and empowerment movements have mobilized the laws of human rights in an attempt to undermine the authority of psychiatric institutions and invalidate entrenched stereotypes about mental illness (Coleman, 2008; Spandler & Calton, 2009). J. Sadler (2009) suggests that in the present, "consumers, service users, and psychiatric survivors are critical of many clinical practices and coercive powers in psychiatry, and a historically oppressed population is gaining dignity in choice and voice" (p. 414). Indeed, the burgeoning and interdisciplinary field of Mad Studies in Canada is arrayed against biomedical psychiatry, aimed at transforming oppressive and psy-centered languages, practices, ideas, laws, and systems, and connected strongly with activism (LeFrançois et al., 2013). Nevertheless, mental health legislators are tasked with finding a reasonably fair balance between patient autonomy and protection in the wake of the dark history that continues to haunt psychiatry.

Despite strides toward patient empowerment, mental health and psychiatric treatment continues to be heavily influenced by ableism (Kolar et al., 2022). Harmful stereotypes and ableist assumptions have legitimized and formalized non-consensual psychiatric interventions and continue to act as justification for involuntary and coercive treatment practices (Kolar et al., 2022; Rose, 2018). In their analysis of British Columbia's Mental Health Act, Kolar et al. (2022) argue that these texts use protection as a legitimizing discourse to construct people experiencing mental illness as dangerous, vulnerable, and as passive recipients of care, effectively removing their agency. Moreover, the relevant mental health statutes, which vary in nuance by province, are sometimes contradictory. On one hand, all Canadians have the right to treatment refusal (Canadian Medical Protective Association, 2023). On the other, most provinces have involuntary treatment laws which accommodate the right to override patient autonomy by hospitalization and/or treatment against the patient's wishes (Mishara & Wiesstub, 2022). Problems around the provision of patient-centered, quality mental healthcare are further aggravated by an overloaded – and arguably inadequate - mental healthcare system.

As rates of mental illness steadily increase, recent data suggests that Canada might be facing a mental health crisis (Canadian Institute for Health Information, 2021; Canadian Mental Health Association [CMHA], 2023; Mental Health Commission of Canada, 2022). In the past few years especially, the emergence of a novel coronavirus (COVID-19) has led to worsening mental health among Canadians and placed an overwhelming demand on mental health services (Moroz et al., 2020; Robillard et al., 2021). Increasing rates of mental illness are compounded by well-documented barriers to accessing mental healthcare in Canada, including long wait times, cost of services, concerns about stigma, cultural and language barriers, inequities due to geography (e.g., rural communities), and so on (Canadian Institute for Health Information, 2021; Chundari, Mitchell, & Tello, 2022; Lui & Mcintyre, 2022; Moroz et al., 2020).

In 2020, among the 18.1% of Canadians aged 12 and older who reported needing mental health services, roughly 55% felt that their needs were fully met, while the remaining 45% reported that their needs were either partially met or entirely unmet (Statistics Canada, 2021). Across the provinces, the average wait time for a patient seeking mental health treatment in 2021 was 29.2 weeks from referral by a general practitioner to elective treatment (Moir & Barua, 2022). Moreover, disparities in access to mental healthcare might be exacerbated in the face of renewed zeal for the privatization of public health services in Canada (see Gollom, 2023; Wright, 2023). As the Government is repeatedly called upon to invest more resources into mental health services, a question central to the MMS debate is whether and how allowing MAiD for mental illness will impact work towards reducing barriers and improving access to mental healthcare for Canadians. In fact, as this thesis will demonstrate, the issues described in the preceding paragraphs – the discord between mental illness as a biological object or social condition, the challenge of finding balance between autonomy and protection, and a burgeoning mental health crisis – resurface in the expert debate around MAiD for mental illness.

1.3.3 Assisted Dying and Mental Illness

Over the last thirty years, assisted dying has been part of a larger discussion regarding end-of-life care in Canada which has focused predominantly on physical terminal illnesses. A growing body of literature deals with the ethical and legal challenges encountered in offering MAiD (Downie & Schüklenk, 2021; Koksvik, 2020; Nielson, 2021; Schiller et al., 2019) and explores the perspectives and experiences of healthcare providers and caregivers involved in assisted dying (Brooks, 2019; Goldberg et al., 2021; Hales et al., 2019; Ho et al., 2022; Wright et al., 2015). However, the bulk of literature that deals specifically with assisted dying for mental illnesses comes from the handful of jurisdictions – the Netherlands, Belgium, Luxembourg, and Switzerland – in which the option of assisted death is already available to those suffering solely from mental illness (see Dierickx et al., 2017; Evenblij et al., 2019; Kim et al., 2016; Thienpoint et al., 2015;). Moreover, although psychiatric euthanasia remains relatively uncommon in comparison to aid in dying for physical terminal conditions, its use appears to be rising (Grassi et al., 2022). Accordingly, Canada has looked to evidence from its European counterparts to inform ongoing discussions about the evolution of MAiD. In addition to cutting across geographical borders, the scope of assisted dying research crosses several disciplinary boundaries. As a result, the extant literature comes from a wide variety of disciplines, such as philosophy, law, medicine, bioethics, sociology, and communications.

Until recently, literature on assisted dying for mental illness has been largely conceptual. Conceptual studies – including commentaries, essays, editorials, and reviews – debating the moral, legal, and medical grounds for assisted dying in the context of mental illness reveal key concepts around which arguments are organized in the debate. For example, they expose unresolved disputes over autonomy (Denys, 2018; Varelius, 2015, 2016), vulnerability (Rooney et al., 2018; Stainton, 2019), irremediability (Bahji & Delva, 2021; Rooney et al., 2018), capacity (Platt, 2020; Shaw et al., 2018), suffering (Trachsel & Jox, 2022; Verhofstadt et al., 2017), hope (Berghmans et al, 2013; Blikshavn et al, 2017), and suicide prevention (Kim et al., 2018; Kious & Battin, 2019). Treatment-resistant depression is used in several conceptual studies as the exemplary condition to illustrate the (im)possibility of MMS (Bonnie, 2017; Platt, 2020; Schüklenk & Vathorst, 2015; Steinbock, 2017; Tully, 2022). Although this body of literature necessarily highlights some of the central tensions that emerge from the debates, it has been criticized as imprecise and spurious by opponents of the practice who raise serious concerns about the scarcity of published empirical literature (Mehlum et al., 2020; Sinyor, 2021).

For many years, the only available data for research into psychiatric EAS in practice were case summaries. As a result, empirical research has been largely concentrated in reviews of cases reported to the Euthanasia Review Committees in the Netherlands and Belgium or retrospective reviews of individual cases (see Legvenyte et al., 2020; Nicolini et al., 2020 for example). Two landmark studies using these methods are routinely cited as evidence about the reality of the practice. Moreover, these two studies are often used to support the continued prohibition of assisted dying for mental illness in jurisdictions where it is not yet permitted.

The first study, a 2015 research paper published in the *British Medical Journal*, was produced by a handful of psychiatrists in Belgium who aggregated data from one hundred patients who were assessed for assisted death in the clinic of one consulting psychiatrist between 2007 and 2011 (Thienpont et al., 2015). They found that patients suffered from a wide variety of problems, including mood and personality disorders, post-traumatic stress, anxiety disorders, eating disorders, schizophrenia, addiction, autism, and grief, most with comorbidities. The outcome of the study (37 patients euthanized out of 48 approved; 38 withdrawals of requests out of 100 applications; 11 postponing of euthanasia after request granted; and five independent suicides) has been cited to support doubts about determinations of capacity and treatment resistance in people with mental illness (see Charland et al., 2016 for example).

The second article was published in 2016 and written by American psychiatrist Scott Kim and colleagues. They reviewed 66 individual case summaries of persons who received psychiatric EAS in the Netherlands (Kim et al., 2016). Like the Belgian study, Kim et al. (2016) found that euthanasia was provided to people with a variety of psychiatric conditions including severe depression, psychosis, cognitive problems, autism, grief, and substance abuse. The authors reported that most psychiatric EAS requesters identified as women with personality disorders who were described in case notes as “socially isolated” or “lonely”. These findings were later echoed by Nicolini et al., (2022) who claimed that women account for a large percentage of people who request and receive psychiatric EAS. However, the purported gender gap has received little scholarly attention. Kim et al. (2016) also discovered frequent disagreement among the physicians involved in the decision over whether regulatory criteria were met in EAS assessments. Taken together, the results of these two studies appear to support many of the concerns raised by opponents of MMS.

More recent empirical research offers insight into the opinions, attitudes, and experiences of a variety of MAiD actors. Qualitative research includes surveys and interviews conducted with the general population (Kowalinski et al., 2022; Levin et al., 2020; Plaisance et al., 2022), healthcare providers (Evenblij et al., 2019; Montreuil et al., 2020; Rousseau et al., 2017; Verhofstadt et al., 2021), relatives (Pronk et al., 2021b; Snijdewind et al., 2022), and patients themselves (Pronk et al, 2021a; Verhofstadt et al., 2022), though research capturing the voice of the latter two populations remains scant, revealing a critical gap in the literature. It is difficult, and arguably unethical to craft legislation without consulting those with lived experience of mental illness: the target population of the proposed amendments to Canadian law. The limited research which has integrated the voice of patients and their relatives has demonstrated the potential for the practice to have positive impacts for both parties. For example, in their interviews with patients suffering from mental illness, both Pronk et al. (2021a) and Verhofstadt et al. (2022) found that the psychiatric EAS assessment process paradoxically allowed some individuals to reconsider alternatives toward life, providing them with peace of mind and increasing their willingness to attempt new treatment options. In interviews with partners of patients who had received an assisted death due to a mental disorder in The Netherlands, Snijdewind et al. (2022) found lower grief reactions in the bereaved partners. They hypothesized that the "expectedness of the death of the partner, lack of suffering of the partner at the time of dying, and presence of physician support may in part explain the protective effects of [EAS] against severe grief reactions" (Snijdewind et al., 2022, p. 8).

As evidenced above, only a small fraction of existing research into assisted dying for mental illness focuses on the Canadian context. Although this is likely because the practice has yet to be legalized, I maintain that the literature could benefit from research into the ongoing controversy, especially considering the longevity of the Canadian debate and the international attention that it has received. The major themes and tensions that drive the debate are worthy of investigation to garner a deeper understanding of the contentiousness surrounding the phenomenon. To my knowledge, there is little inquiry into the discourses around the prospect of MMS and no academic investigation into the construction of MAiD for mental illness among experts, despite their significant role in the development of MAiD policy. As such, this thesis will fill a gap in Canadian MAiD literature and assisted dying literature in general. Furthermore, this thesis represents one of the first anthropological studies of assisted dying with an explicit focus on mental illness.

1.3.4 Anthropology and Sociology of Assisted Dying

Only recently has the phenomenon of assisted death started to gain meaningful anthropological and sociological attention. The small collection of literature, however, does not reflect the disciplines' interest in the phenomenon. At least since the late nineteenth century, anthropologists have published extensively on diverse aspects of death and dying (Kiong & Schiller, 1993). French sociologist Robert Hertz' (1960) study on secondary burial treatments in Dayak society laid important foundations for the anthropological study of death as a distinct field by suggesting that death should be seen as a social event. Following this seminal contribution, a large body of literature has explored death as a social process rather than as an instantaneous biological event, wherein the boundaries between life and death are somewhat ambiguous (Goodwin-Hawkins & Dawson, 2018; Palgi & Abramovitch, 1984). Around the time that anthropology began its move away from studying the "exotic" toward an "anthropology at home" (Peirano, 1998), the discipline saw an increasing interest in the culture that surrounds death and dying, the role of medicine in death, and the broader social, economic, and political processes and debates concerning life's end.

According to Kaufman and Morgan (2005), late twentieth and early twenty-first century research responded to the shifting politics, ethics, and discourses about the end of life that accompanied developments in biomedicine. In their landmark study, *Awareness in Dying*, Glaser and Strauss (1965) conducted field work in six American hospitals. Through observations of the social interactions between dying patients and hospital staff, they defined four contexts of awareness specifying "who, in the dying situation, knows what about the probabilities of death for the dying patient" (Glaser & Strauss, 1965, p. ix), thus offering novel insight into how modern American hospitals shape the dying trajectory. Since then, many scholars have investigated the ways in which biomedical intervention at the end of life increasingly complicates dying and have examined the ways in which death is organized and allowed – or not – to occur. Prominent studies have looked at controversies surrounding issues such as brain death (Lock, 2002), organ donation and trafficking

(Scheper-Hughes, 2004), hospital bureaucracy (Kaufman, 2005) and palliative care (Barrett, 2022; Long, 2005). Research within these socio-medico-legal spheres has undoubtedly foregrounded social scientific inquiry into assisted dying.

Although the volume of work remains modest, and virtually non-existent concerning an explicit focus on mental illness, anthropologists have begun to focus on the lived experiences of assisted dying and the ways that people grapple with their mortality in the face of debilitating medical conditions. Anthropological inquiry into assisted death has been largely ethnographic, with researchers studying the social features and processes that characterize the practice within its unique context. In a handful of the jurisdictions where MAiD is legal, anthropologists have followed patients, families, and healthcare providers through their requests, deliberations, and in some cases, their assisted deaths (Buchbinder, 2021; Gandsman, 2018; Hannig, 2022; Norwood, 2020; Stavrianakis, 2020). They have also engaged with activists and other stakeholders by attending and participating in public MAiD-related events such as hearings, campaigns, workshops, meetings, and conferences (Gandsman 2018; Hannig, 2019,2022; Richards, 2017). Research has been relatively restricted to those who provide, make use of, or advocate for assisted dying (i.e., proponents), though the viewpoints of opponents feature from time to time.

An essential anthropological perspective on assisted dying comes from Frances Norwood's (2020) *The Maintenance of Life*. In this ethnography, Norwood (2020) explores euthanasia in the Netherlands, where the practice has been legal for over twenty years, through in-depth interviews and fifteen months of participant observation with dying persons, their loved ones, and healthcare practitioners. The book is composed of three sections that moves from the larger context to individual narratives to cross-cultural comparison and policy implications, but it is ultimately focused on the Dutch experience with euthanasia and how end-of-life discourse, or “euthanasia talk”, facilitates sociality. The text demonstrates how participant voices can be brought to the fore of assisted dying debates, the capacity of qualitative research to inform policy recommendations, and is helpful in anticipating what the future of MAiD could look like in Canada. Norwood’s (2020) ethnography offers a captivating example of how to do an anthropology of assisted dying, and a handful of contemporary anthropologists around the world appear to have heeded her call for more ethnographic studies (see Buchbinder, 2021; Gandsman, 2018; Richards, 2017; Stavrianakis, 2020).

While the bulk of empirical social scientific studies of MAiD are ethnographic, qualitative interview and survey studies (Buchbinder, 2021; Karsoho et al., 2017; Pronk, 2021a, Rajkumar, 2021; Sikora, 2009; Verhofstadt et al., 2022), historical analyses (Lavi, 2005; Van Hooff, 2004), conceptual and theoretical inquiries (Kubiak, 2021) linguistic analyses (Gandsman, 2018; Hannig, 2019) and comparative studies (Blouin, 2021; Hamarat et al., 2022; Kripper & Kasian, 2009) are also found in the literature. Through this research, scholars have helped to elucidate various stakeholders’ attitudes and opinions about the practice, the norms and expectations of behaviour for the actors involved in assisted dying, the imagined versus practical enactment of regulations that govern the practice, and the arguments that fuel assisted dying debates. Although most of the extant literature does not focus explicitly on MAiD for mental illness, past anthropological inquiry provides various insights that are especially relevant to the MMS debate.

Much of the research on the right-to-die movement focuses on the autonomy and choice arguments of proponents. Assisted dying rhetoric often embraces a neoliberal approach to health based on self-governance, individualism, and personal responsibility, which depicts assisted dying as the ultimate and final “triumph of autonomy” (Beauchamp, 2006, p. 644). According to Gandsman (2018), “such conceptions imply a more socially atomistic view of the individual premised on self-ownership” (p. 331). Other scholars similarly maintain that in the dominant assisted dying rhetoric, death is materialized into a scripted event that is both authored and made (Buchbinder, 2021; Hannig, 2019). From this perspective, a good death is equated with death that is directed and controlled by the dying person. However, drawing on ethnographic field research with physicians, patients, families, hospice workers, activists, lawyers, and more in Oregon and Washington, anthropologist Anita Hannig (2019) describes an inherent tension between the authorship and authorization of death. She suggests that pro-assisted dying activists simultaneously rely on the language of individual autonomy and deny in various ways the singular authorship of the act by displacing agency onto medicine and the state to authorize and facilitate death. Likewise, Ari Gandsman’s (2018) work with right to die activists in North America and Australia highlights the core struggle between autonomy and the forces that seek to constrain such freedom. Paradoxically, anthropological investigation reveals that despite the centrality of autonomy and control in pro-assisted dying rhetoric, in practice, assisted dying revitalizes a patient’s dependency on the state and is replete with barriers that complicate and challenge MAiD’s public image as the ultimate manifestation of free will (Buchbinder, 2021; Gandsman, 2018; Hannig, 2022; Kubiak, 2020; Norwood, 2020; Stavrianakis, 2020).

In addition to demonstrating the critical role that others (i.e., healthcare practitioners, relatives, the state) play in facilitating or preventing a patient’s assisted death, anthropological research reveals the “choice” of assisted dying to be heavily constrained and unequally distributed. In most jurisdictions, assisted dying occurs within a medical framework, and ethnographic research shows that it is subject to similar disparities and barriers as other medical interventions and serves a predominantly white and privileged demographic (see Buchbinder, 2021; Hannig, 2022; Norwood, 2020; Stavrianakis, 2020). In *Scripting Death: Stories of assisted dying in America*, Buchbinder (2021) dedicates an entire chapter to sharing stories that describe the various constraints that patients confront in navigating access to aid in dying – such as lack of access to information, lack of providers, cost barriers, legislative safeguards, etc. - to argue that the opportunity die by MAiD is not equally available to everyone. Taking cues from recent scholarship on reproductive justice, Buchbinder (2021) further notes that choice itself is often a privilege, that the “presumed universality of certain core rights masks critical disparities associated with race, class and other key social identifiers” (p. 134), and that “well-intentioned policies designed to protect vulnerable groups may at times have unexpected and paradoxical effects” (p. 135).

Beyond raising issues about stratified access to aid in dying and health care justice, social scholars have also drawn attention to the enduring concern that “what seems on the surface to be a voluntary act, the rational decision to end one’s life, may actually be the product of social expectations” (Mwaria, 1997, p. 862) or circumstances. What Mwaria (1997) is referring to here are the hidden or implicit external pressures and societal rules to which individuals are expected to conform. She gives the example of the Shoshone, whose old/infirm persons would abandon the group to die and avoid becoming a burden to others (Mwaria, 1997). Concerns about external social pressures are particularly relevant to objections to MMS as they speak to broader contextual pressures that may unconsciously influence a person toward death such as ableism, stigma, or poverty. In a recent essay for *American Ethnologist,* anthropologist Sophia Jaworsky (2022) writes skeptically about expanding access to MAiD without addressing the social and structural oppression facing many Canadians (e.g., housing crises), arguing that "a progressive ethics of "choice" may in fact lead to eugenicist outcomes" (para. 10). Indeed, anthropologists have regularly challenged perceptions of aid in dying as being wholly focused on the individual, arguing instead that MAiD is intrinsically social.

The significance of an assisted death is sometimes reduced to the final hours of life and the physical act of hastening death (Karsoho et al., 2016). However, anthropologists have remarked on assisted dying's greater ability to foster sociality in life (Gandsman, 2018; Kaufman & Morgan, 2005; Norwood, 2020). Several studies have found that the network of support that is formed through an assisted dying request serves a palliative function, prolonging life by staving off social death (Karsoho et al., 2016; Norwood, 2020; Pronk, 2021a). Gandsman (2018), for example, describes how activists in Australia and North America reported that simply having the power to end one's life enabled them to be better engaged with the question of living. Pronk et al., (2021) similarly found that allowing MAiD for mental illness counterintuitively enhanced patients' wellbeing by providing peace of mind, reducing suffering and, ultimately helping them to live longer amidst subjectively intolerable circumstances. These findings might help explain why, where assisted dying is lawful, a noticeable percentage of approved requests to die are not fulfilled, indicating that people may have reconsidered their decision (Calati et al., 2021).

In the literature, assisted dying has also been framed as an ethics of care, or as a way of enacting care for others (Buchbinder, 2021; Gandsman, 2018; Stavrianakis, 2020). Canadian Anthropologist Ari Gandsman develops this idea through his description of assisted dying as a "final gift" (2018, p. 335) from the dying person to their loved ones. The final gift involves accessing MAiD to prevent loved ones from experiencing the trauma of having to witness and remember the decline towards death and is also a "performance of dignity for others" (Gandsman, 2018, p. 335). Likewise, Richards (2017) suggests that a person's desire for MAiD might speak to who they were as a person more so than their reaction to a terminal prognosis, "reflecting something of their character or the values they subscribed to in life" (p. 11). Through their transition from life to death, Richards (2017) maintains that "it is envisaged that the character of life embodied can be preserved even if the body itself is voluntarily sacrificed" (p. 353). Such continuity is not afforded in the same way in situations of suicide or sudden death (Hannig, 2019; Timmermans, 2005). The recurrent theme of sociality in assisted dying research reveals the impact of MAiD beyond the physical death of the dying person, and the importance of qualitative investigation into the practice.

Ultimately, anthropologists seek to understand the socio-cultural contexts within which assisted dying has emerged and continues to evolve. According to Richards and Krawczyk (2021), "assisted dying only succeeds in becoming lawful in the first place when proponents are successful in attaching cultural scripts about the virtues of assisted dying to pre-existing, already socially-accepted cultural scripts about the postmodern 'good death'" (p. 18). This idea of a "culturally appropriate death" was elaborated by Timmermans (2005), who argued that culturally appropriate death relies on adhering to cultural scripts that imbue death with positive meanings and resonate with widely shared societal values and norms. For instance, Richards and Krawczyk (2021) write that the increase in lawful assisted dying is a result of "the growing cultural belief that pain and suffering at the end of life are meaningless, biographically disruptive, and therefore need to be eradicated" (p. 64). Several scholars agree that evolving assisted dying legislation and notions of illness and death are fundamentally shaped by collective beliefs, values, and normalizing bodies, including law and medicine (Kubiak, 2021; Norwood, 2018; Richards & Krawczyk, 2021). Thus, in true anthropological fashion, this study seeks to understand how the debate around MMS and its constituent discourses both shape and reflect collective cultural values in Canada.

1.3.5 Discourse, Framing and Assisted Death

According to Fairclough (1995), changing discursive practices are an important part of wider processes of social and cultural change. Likewise, O'Connor and Payne (2006) maintain that social issues often "develop through the push and pull of conflicting discourses, communicated to the community in different ways, raising awareness of an issue, and forcing political debate" (p. 830). Thus, I contend that the arguments that circulate in MAiD debates, and the more general discourses they refer to and produce, provide a lens through which to study social and cultural change. Indeed, several scholars have demonstrated how discourse relates to assisted dying, most prominently through the study of news media coverage (Booth & Blake, 2022; Crumley et al., 2019; McInerney, 2006; Rietjens et al., 2013; Wright et al., 2015) or discourse analysis of interviews (Karsoho et al., 2016; Lamers et al., 2015; Norwood, 2020), but also through the examination of social media discourses (Lalancette & Yates, 2020; Jaye et al., 2021), policy documents (Borgstrom & Walter, 2015), and legal artefacts (Karsoho et al., 2016). Although these studies analyze important representations of assisted dying, none analyze construction that emanates from expert discourses nor focus explicitly on mental illness, as I do in this study. This study was guided by two understandings of discourse that have been employed in existing literature on assisted dying.

The first is anthropologist Frances Norwood's (2020) notion of 'euthanasia talk', which she coined in her seminal ethnography of euthanasia in the Netherlands to describe the discourses that are formed through end-of-life discussions. She distinguishes the act of euthanasia from euthanasia talk and draws on Foucauldian understandings of discourse to define the latter as a "collection of statements, the rules for the formation of those statements, and the practice of circulation and exclusion" (Norwood, 2020, p. 25). According to Norwood (2020), "the consequences of discourse are enormous… discourse produces knowledge in forms that we come to think of as normative, and in doing so, obscures its very nature – that it is a cultural form that shapes the way we think, feel, and act" (p. 25), thus informing collective consciousness. Moreover, discourse "limits what can be spoken, what is constituted as taboo, what is held in collective conscience, what is reconstituted from the past and who in society has access" (Norwood, 2020, p. 13). Therefore, I assert that experts publicly engaged in Canadian MAiD talk - and the discourses they construct - play a significant role in defining the parameters of the MMS debate, including shaping and reflecting collective values and beliefs about mental illness.

The second understanding of discourse comes from Karsoho et al. (2016) qualitative investigation into proponents' articulations of suffering and medicalisation in *Carter v.*

Canada, where they draw on Potter's (1996) work to describe discourse as "talk and text in action" (p. 191). This notion of discourse proceeds from the assumption that language is used to accomplish something; it is a "medium of action" (p. 192). Karsoho et al. (2016) apply this understanding of discourse to argue that proponents' articulation of suffering does not at all challenge, but instead, "makes productive use of the larger framework of the medicalization of dying (p. 188). Following a similar approach, I consider what is said by experts as the strategic deployment of language to advance specific agendas (Karsoho et al., 2016). For example, I question what legal, moral, or political aims are advanced by describing concepts – like mental suffering – in particular ways in the debate and attend to the ways in which "meaning is produced and to what effects" (Karsoho et al., 2016, p. 191). Intimately tied to this idea of discourse and social movement actors as strategic agents is the notion of framing.

Originally inspired by the sociological work of Erving Goffman, several academic investigations into assisted dying have demonstrated the utility of framing in analyzing the debates (Atwood-Gailey, 2003; Burlone & Richmond, 2018; Karsoho et al., 2016; Wright et al., 2015). Frames are useful for explaining similarities and differences in mobilization among various actors on a given issue; as McInerney (2006) states: "frames are themselves discursive strategies designed to construct meaning and 'reality' in ways that will further movement ends" (p. 656). In her analysis of the media's framing of the right-to-die controversy in the United States, Atwood-Gailey (2003) defines a 'frame' as an "interpretive schemata that simplifies and condenses the 'world out there' by selectively highlighting certain information" (p. 6). Likewise, Altheide and Schneider (2013) define a frame as "the focus, a parameter or boundary, for discussing a particular event" (p.

53). Theoretically, frames are crucial in defining situations because they clarify the essence of an issue by zooming in on particular ideas (Altheide & Schneider, 2013; Lindekilde, 2014).

Some examples of the frames used to debate assisted death in the media include legal; social; and medical (Atwood-Gailey, 2003); moral and rational (Burlone & Richmond, 2018); and political and economic (Holody, 2012). As one of the few authors to focus on assisted dying frames in the Canadian context, Burlone (2019) argues that MAiD's framing does not end with the adoption of legislation, but that the mere implementation of law "nourishes an ongoing framing process" (p. 1104), and that amendments, like Bill C-7, inevitably trigger a reframing of the issue. By elevating certain frames over others, I maintain that the way in which experts' construct MAiD for mental illness informs public perceptions of the practice and drives policy in a particular direction.

1.4 Significance and Thesis Outline

There are few ethical issues that prompt more passionate debate than end-of-life decisions (Cutliffe & Links, 2010). As per Mishara and Weistub (2013):

> In debates about euthanasia and assisted suicide, it is rare to find an article that begins with an expression of neutral interest and then proceeds to examine the various arguments and data… Positions tend to be clearly dichotomized: either one believes that the practice of euthanasia or assisted suicide is totally acceptable or completely unacceptable in a just and moral society. (p. 427)

Indeed, the debate around MMS is unequivocally polarizing, and the circulation and leveraging of competing expert discourses have a profound influence on public opinion and policy formation. This thesis contributes to a deeper understanding of the issues that surround MMS by concentrating on the themes, frames, and discourses that permeate expert argumentation. As lawmakers in Canada try to establish rules and principles for who might qualify for a right to die, this study investigates the values, meanings, and assumptions that underlie arguments driving the debate and queries what dominant discourses reveal about larger cultural notions of mental illness. Importantly, by presenting arguments from all sides of the expert debate as equal and valid, this study encourages the reader to form their own opinion on the issue.

To my knowledge, there has been no research into expert discourses around MMS in Canada and limited anthropological inquiry into assisted dying for mental illness. As such, this study helps fill a gap in both anthropological and Canadian MAiD literature. At the time of writing, Canada is less than one year away from the scheduled repeal of the exclusion which bans those suffering solely from mental illness from accessing MAiD. Regardless of whether the timeline is respected, this research demonstrates that the MMS debate has a much greater impact than the people who might ultimately use it by influencing the cultural conversation about mental illness and psychiatry. Moreover, although I have conducted this research in the Canadian context, I expect that it could be relevant to other jurisdictions where similar discourses might erupt as the assisted dying movement continues to evolve worldwide.

In Chapter Two I discuss the ethnographic content analysis (ECA) method used in this study, the rationale behind my chosen ethnographic context and the process of data collection and analysis. Chapter Three explores the legal rights frame and discourses that emerged from my analysis and some of the key themes around which actors constructed their arguments within the debate. I argue that the rights-based arguments deployed by experts reveal noticeable differences in experts' conceptualizations of mental suffering and might reflect an enduring contentiousness around the medicalisation of mental illness. In Chapter Four, I shift my focus to a clinical ethics frame and explore how experts present the appropriate role of medicine – psychiatry in particular – in MAiD. I also consider what these discourses reveal about the state of mental healthcare in Canada and argue that an underlying critique of psychiatry reinforces its marginalized status within the hierarchy of medicine. Throughout Chapters Three and Four, I demonstrate how experts use juxtaposition – of mental and physical illness, and of psychiatry and other branches of medicine – and engage with various themes and discourses to advance their respective positions on MMS. In Chapter Five, I conclude by synthesizing my findings, discussing the implications of this research, and suggesting avenues for further inquiry. I argue that the discourses by which the expert debate is conducted not only speak to problems specific to assisted dying, but also reveal a lot about perceptions of mental illness and psychiatry. Ultimately, I contend that the MMS debate reflects a larger call for a reassessment of mental healthcare in Canada.

CHAPTER 2: METHODOLOGY AND METHODS

In the early stages of my master's programme, I imagined that I would investigate MMS through immersive participatory research with advocates of the practice. However, in the search for literature to inform my proposal, amidst a glaring absence of empirical research into the issue in the Canadian context, I discovered a wealth of publicly accessible online material, especially news media and public statements. As I read through dozens of documents, repeated arguments and underlying tensions began to emerge, and I became interested in how rhetoric was being used to shape the debate around MAiD for mental illness. I noted that many authors cited experts in their discussions of MAiD, presumably to bolster their claims. As I dug deeper into the issue, I became attuned to the critical role played by experts in both the parliamentary process and public awareness of the practice. From my perspective, the expert debate constituted a forum through which I could glean a more comprehensive understanding of the arguments informing the debate and ultimately guiding Canadian mental health law and policy.

In this study, I utilized ethnographic content analysis (ECA) informed by Altheide and Schneider (2013) in conjunction with Carvalho's (2008) framework for discourse analysis to explore the construction of MMS in the expert debate. In this chapter, I first describe the value of ECA and the rationale behind the ethnographic context with which I chose to engage. Next, following the twelve-step procedure suggested by Altheide and Schneider (2013), I recount the processes of data collection and data analysis. Lastly, I consider the limitations of my methodology.

2.1 Ethnographic Content Analysis

2.1.1 What is ECA?

Generally, ethnography, or "writing culture", refers to the written articulation of people[8] and cultures (Clifford & Marcus, 2010), but it can also be conceived as a method (Altheide & Schneider, 2013). According to Altheide and Schneider (2013), a critical component of an ethnographic study is that the researcher undertakes fieldwork by immersing themselves into the context of the research subjects. If the meaning of an activity remains paramount, however, Altheide (1987; 1996) contends that ethnography can also be considered a "methodological orientation independent of specific subject matter" (p. 24), whereby fieldwork simply entails getting deep into the content that is relevant for your research question. Accordingly, the study of products of social interaction, like news media, becomes ethnographic as the "researcher immerses [themselves] in numerous documents, reads them interactively - moving from one point in a document to a related point in another document, then searching still another source" (Altheide & Grimes, 2005, p. 625) until major frames, themes, and discourses emerge. Moving beyond notions of ethnography as physical immersion with human participants, ECA conceptualizes sets of documents as the research field (Altheide & Schneider, 2013).

ECA was first proposed by sociologist David Altheide to improve upon the enumerative approach common to conventional quantitative content analysis (QCA) (Altheide, 1987). QCA often employs a deductive approach to confirm hypotheses by quantifying the presence of certain words, themes, or concepts in textual data (Bernard et

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[8] While humans continue to be a primary focus of anthropological study, they are not the only subjects of interest. The ontological turn in the discipline (Kohn, 2015) has contributed to an emergence of multispecies ethnographies that investigate how humans relate to various hosts of nonhuman beings like plants and fungi for example (see Kohn, 2015; Miller, 2019; Tsing, 2015).

al., 2017). Although ECA can similarly be used to verify theoretical relationships, its major competence is that it promotes the discovery of potentially disconfirming evidence and new or emergent patterns (Altheide & Schneider, 2013). Rather than following the “positivist convention of QCA of forcing the latter into predefined categories” (Altheide & Schneider, 2013, p. 26), this method of qualitative analysis supports a more inductive approach wherein novel codes and themes are expected to emerge from the data through the researcher, much like grounded theory (see Glaser & Strauss, 1967). ECA treats text as symbolic representation, with the aim of defining and describing emerging patterns within a set of documents and eliciting meaning from the messages conveyed through frames, themes, and discourses (Altheide & Schneider, 2013).

2.1.2 Ethnographic Context

In ECA, the researcher, actively seeking immersion in the texts, elicits themes that illustrate how a particular issue is presented and how those presenting the problem might understand and construct it given their position in the culture within which the document was produced (Altheide, 1996). During my preliminary investigation into the issues surrounding the prospect of allowing MAiD for mental illness in Canada, I noticed that the term ‘expert’ was regularly invoked by journalists in both news headlines and the bodies of articles (see Bryden, 2020; Kirkey, 2022; Moran, 2020). The use of titles such as ‘expert’, ‘doctor’ and ‘professor’ lend more credibility to the arguments presented by claiming to refer to authorities on the matter whose judgments are often deemed more credible than lay perspectives and can be persuasive to citizens (Adekola et al., 2019; Johnston & Ballard, 2016). As such, the circulation of competing discourses among so-called experts is significant because they can inform public opinion and policy formation (Christensen, 2021). For example, physicians, whose profession is deeply entwined with MAiD, not only hold a privileged place in society for swaying public opinion on the issue (Wright et al., 2015), but are also routinely asked to testify in court and to conduct research to inform policy and practice protocol (Council of Canadian Academies, 2018; Health Canada, 2022b). Physicians and medical associations are prominent voices in shaping the parameters of the MAiD controversy, however, they do not have a monopoly over the issue.

Others, who have expert knowledge within a field or discipline relevant to MMS- such as bioethics, law, or health policy - that allows them a particular insight into the debate as well as stakeholders who hold a vested interest in the matter also play a significant role in the formation of the issue (Revell-Dennett, 2018). As per Blouin et al., (2022), these “moral entrepreneurs” (p. 1559) play a major role in informing the judgements the public and institutions make toward assisted dying. Indeed, the values and assumptions underlying the arguments deployed in the expert debate and the language that is used to construct the issue enables and constrains certain perceptions of MAiD and mental illness. Moreover, Meling (2022) writes that “in the context of cultural policy, many different stakeholders may be considered ‘experts’” (p. 650). For the purposes of this study, experts included healthcare practitioners, lawyers, scholars from a range of academic disciplines, policy analysts, legislators, researchers, and other major stakeholders who might impact or be impacted by MMS, including assisted dying and mental health organizations [9].

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[9] Of course, this selection of experts does not represent all relevant voices in the MAiD MD-SUMC debate. There are others with expertise, including economists and politicians for example, and those with lived experience of mental illness, who also significantly inform the extent of the debate and practice in Canada.

2.1.3 Why Choose ECA?

The scarcity of empirical literature on the topic combined with ever-evolving MAiD legislation led me to seek a systematic, yet flexible qualitative method that would encourage immersive engagement with the data and permit a primarily inductive approach. In ECA, pre-established codes or themes derived from existing literature can initially guide the study, but others are allowed and expected to emerge from the data (Altheide & Schneider, 2013). For instance, some of the predetermined codes used to characterize prevailing arguments in the debate included “autonomy”, “vulnerability” and “religion”. Partway through reviewing my dataset, it became clear that religion-based arguments were rarely invoked by experts in the debate about MAiD for mental illness, despite their prevalence in broader assisted dying debates (see Atwood-Gailey, 2003; Macauley, 2019). Thus, the “religion” code was discarded. As data analysis progressed, examples of codes that were added include “evidence-based care” and “ableism”. In addition to the advantages of an iterative and inductive approach, the reflexive character of ECA makes it well suited for the study of a controversial moral issue.

Reflexivity is a cornerstone of ECA and was a crucial aspect of this study. In their description of ECA, Altheide and Schneider (2013) encourage the researcher to check their biases, keep record of their assumptions and consistently reflect on how certain statements and documents make them feel through constant comparison. My goal was to critically analyze and portray the arguments deployed in the expert debate as accurately and fairly as possible without advancing a particular moral position on MMS. It was important to me that reflexivity was exercised extensively throughout the research process to avoid validating one set of arguments over others in my analysis. Following Saldaña’s (2021) recommendations, throughout the duration of the study I recorded “what surprised me?”, “what intrigued me?” and “what disturbed me?” to track my assumptions, my positionality, and any tensions with my values and belief systems. Throughout data collection and analysis, I tried to remain conscious of how my experiences, opinions, and biases might influence my interpretation of the data.

2.2 Data Collection & Data Analysis

Unlike QCA, ECA follows a recursive and reflexive movement between concept development, sampling, data collection, coding, analysis, and interpretation (Altheide & Schneider, 2013). Nevertheless, Altheide and Schneider (2013) suggest a flexible five-stage process comprising twelve steps to help guide an ECA study. I followed these steps to gather my dataset and guide data analysis. I did not deviate from the suggested procedure except to supplement ECA’s analytic strategy with Carvalho’s (2008) framework for discourse analysis. The five stages of this project are detailed below.

2.2.1 Stage 1 - Documents

The first step in any ECA study is to identify an issue, develop a research question, and familiarize oneself with the existing literature on the topic (Altheide & Schneider, 2013). The completion of this first step is illustrated by the first chapter of this thesis, which describes the context of the controversy surrounding MMS, identifies my research objectives, reviews the relevant literature, and outlines the significance of this study.

The second step is to become familiar with the context of the information source(s) and to explore possible document sources (Altheide & Schneider, 2013). Although ECA projects often analyze documents from a single medium (e.g., news media), several studies have successfully applied ECA to examine documents from two or more different mediums (see Bernhard, 2010; Gibbs Van Brunschot & Sherley, 2005; Murray, 2011; Porter, 2008).

This study used a multi-medium approach and collected news and magazine articles, commentaries, and stakeholder position statements to compile a balanced textual sample of the expert debate. Newspaper and magazine articles were included because they are a medium through which experts can convey their opinions to the public and reach a wide spectrum of readers (Altheide & Schneider, 2013). Unlike more formal publication outlets like scholarly journals, newspaper and magazine articles also allow authors to adopt a more informal tone because they are intended for a general audience and are typically not peer reviewed.[10] They also offer a different type of argument than scholarly publications. A scientific paper, for example, is likely to contain fewer blanket statements than an op-ed. Commentaries were included because they invite various expert perspectives on a topic and allow authors to express their opinions by responding critically or favourably to a focal article. For this study, editorial, perspective and reflection articles were included in the category of commentaries and linked focal articles were also included in the dataset. Position statements were included because those with a stake in mental healthcare in Canada – such as organizations responsible for the provision of mental healthcare – will likely feel some of the greatest impacts of the proposed changes to MAiD eligibility

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[10] While experts often have freer rein in opinion editorials than journal articles for example, it is important to note that over half of Canadian media is privately owned. Some of the most popular national presses, such as the *Globe and Mail, National Post*, and so on, are directed by Canadian elites, which has been shown to contribute to a lack of diversity in reporting (Engler, 2016; O'Donnell, 1991; Winseck, 2021). O'Donnell (1991) writes that "the corporate elite that controls Canada's media is linked to other power elites…At least as powerful as Parliament, this unelected group makes the business decisions that shape the economic, political, and cultural future of Canada…" (p. 288). Therefore, the opinions that are published in the private media likely do not represent the full spectrum of expert perspectives. Although it is beyond the scope and purpose of this thesis to delve into issues around media ownership in Canada, it is imperative to remain cognizant and critical of who controls, and ultimately benefits, from what is and is not permitted to be shared in the media.

criteria. Their position on MMS has the potential to influence both service-users and policymakers who rely on stakeholders' experiential knowledge and guidance to inform their decisions (Adekola et al., 2019).

An analysis of documents from a single source, like newspaper articles for example, could be appropriate to investigate general perspectives on MMS or expert perspectives on MAiD in general. However, given my exclusive focus on expert perspectives on MMS, I determined that collecting documents from a single medium would result in too small of a sample size to generate a robust analysis and to ensure that the patterns identified could be generalized (Bernard et al., 2017). Therefore, I opted to draw from a variety of sources to better capture the breadth of the expert debate. No effort was made to distinguish categories of experts nor to classify news articles, commentaries, or position statements themselves. Rather, the goal was to uncover the common frames, themes, and discourses running throughout these documents.

In the third step of ECA, Altheide and Schneider (2013) recommend reviewing approximately six to ten documents to determine the unit of analysis (i.e., the portion of the article used for analysis). I reviewed six documents from each medium and determined that information relevant to the author's position, including arguments, key concepts, and discursive strategies, could be found at various points throughout the texts, from the title through to the concluding remarks. Therefore, I analyzed all documents in their entirety.

2.2.2 Stage 2 - Protocol Development and Data Collection

The fourth step in ECA is to create a draft protocol sheet, or data collection instrument, as a guide to extract data from the documents. The primary function of the protocol sheet is to have the researcher "collect information in a format that [will] allow them to elucidate meanings that emerge from the texts through constant comparison" (Altheide & Schneider, 2013, p. 47). For this study, I developed two protocol sheets: one to aid in familiarising myself with my dataset by extracting basic information (i.e., author's name, date published, position for or against MMS, etc.) from the documents (see Appendix A) and another – an extension of the first protocol sheet – geared towards data analysis (see Appendix B). The second sheet integrated Carvalho's (2008) framework for discourse analysis. Steps five and six involved revising the protocol sheets. Revision occurred through pre-testing on several documents in a recursive process of reviewing a document, filling out the sheet, then revising the protocol to better align with the research objectives and incorporate the findings.

The next step, step seven, is to arrive at a sampling rationale. I used a purposive sampling strategy – a method that consists of relying on my own expertise to select materials that will achieve the study goals, without an overall sampling design or quota (Bernard et al., 2017). To ensure that my dataset was linked, I utilized identical inclusion criteria for news and magazine articles, commentaries, and position statements. Documents were included if they:

(I) dealt with MMS as the main topic, as in most of the article's content was about this topic,

(II) focused on assisted dying in the Canadian context,

(III) took a specific position and/or made an argument for or against MMS,

(IV) were written by an expert, defined as a healthcare practitioner, a lawyer, a professor, a policy analyst, a legislator, a researcher, or a major stakeholder,

(V) were published after February 6, 2015 (the date that the *Carter* decision was released), and

(VI) were written in English.

Conditions (I) and (II) excluded articles that mentioned MMS only peripherally in discussion about the morality of assisted dying and other eligibility controversies (i.e., mature minors and advanced requests) or that considered the issue of assisted dying and mental illness, but without reference to Canada or Canadian legislation. Condition (III) excluded descriptive documents that offered overviews of the proposed legislative changes, or which outlined arguments for and against MMS without endorsing one position over the other. It is worth noting that the documents analyzed for this study were mostly written by experts working in Canada, except for a handful of commentaries written by experts working in the United States and England.

Although I considered limiting the dataset to articles written exclusively by Canadian experts, it is important to demonstrate that MAiD talk does not exist without input from or reference to other jurisdictions who are grappling with similar issues. As Blouin et al. (2022) point out, experts have international networks through which they "contribute to the circulation of themes and terms" (p. 1561) and "provide much of the evidence used in court cases, public reports and media accounts, thus constituting the 'facts of the matter'" (p. 1561) in countries that have considered authorizing or expanding assistance in dying. Thus, excluding experts from outside of Canada would have ignored the important role played by these actors in the MMS debate.

While I was collecting documents according to the abovementioned criteria, two major shifts occurred in my sampling strategy. First, I originally proposed to analyze sets of documents from two separate timeframes to reflect what I suspected would constitute distinct "critical discourse moments" (Carvalho, 2008), or periods of time that involved events that challenged or reaffirmed positions on MMS, which could be identified by spikes in news reporting and publications. However, once I began to amass my dataset, it became obvious that although proposed legislative changes have brought mental illness to the forefront of MAiD talk, the debate around MMS is not a recent development. Rather, conversations about MAiD eligibility for those with mental illness have been ongoing likely for as long as assisted dying has been a conceivable reality in Canada. This continuity is exemplified by a special themed issue in the *Journal of Ethics in Mental Health* dedicated to MMS, with publications ranging from 2015 to 2022. To reflect the enduring nature of the debate, I decided to include documents published from February 6, 2015 – the release date of the *Carter* decision – to July 15, 2022.

Second, I planned to analyze reports authored by experts on MMS and included five in my initial dataset. By chance, reports were the last category of documents that I reviewed. Although Altheide (1996) notes that there is no set stage at which data analysis should end in ECA, he suggests that it occurs at the point of data saturation. Likewise, Bernard (2017) maintains that saturation occurs when researchers stop "discovering new categories or relations among categories" (p. 467). As I read through the reports, no new themes or arguments emerged that had not already been extracted from the previous document types. In other words, the information in the reports did not allow for new or unique interpretations or analysis (Bernard et al., 2017). Moreover, the position taken by the authors of the reports was much more difficult to discern than it was in either the news articles, commentaries, or position statements. Some reports claimed a position of neutrality or ambivalence toward MMS, thus not fulfilling my inclusion criteria. These factors, along with the sheer length of the reports, led me to exclude them from my final dataset.

Although the inclusion criteria were identical for all documents included in the dataset, the search strategies for the various types differed and progressed as follows:

News and Magazine Articles: News and magazine articles were identified using the news database Nexis Uni (formerly Lexis Nexis). A search was performed using the terms “(euthanasia OR “assisted suicide" OR “assisted dying" OR “medical assistance in dying” OR “maid” OR “physician assistance in dying") AND (psych* OR mental)” between February 6, 2015, and July 15, 2022. The search was filtered by setting the “publication type” to newspapers and magazines, the “language” to English, and the “geography of the document” to Canada. Additional documents were identified by searching with key terms within news and magazine websites themselves such as *The Conversation* and *Policy Options*. Some websites even had sections devoted to articles about assisted dying. For example, I identified five documents by browsing the “Death and Assisted Dying” category on the *Impact Ethics* website.

Commentaries: To collect commentaries, I first conducted a search with the search terms “(euthanasia OR “assisted suicide" OR “assisted dying" OR “medical assistance in dying” OR “maid” OR “physician assistance in dying") AND (psych* OR mental)” in Scopus and PubMed to develop a list of journals within which to search. From this list, I used the same search terms across the following academic journals: the *Canadian Journal of Psychiatry,* *Journal of Medical Ethics, Bioethics, Canadian Medical Association Journal, Journal of Ethics and Mental Health, Frontiers in Psychiatry, JAMA Psychiatry, the International Journal of Law and Psychiatry* and *Canadian Family Physician.* Filters were used to restrict publication dates and if it was an option, to retrieve only commentary-style articles. After completing these searches, two additional search strategies were performed on all articles extracted from the database: first, a backward citation screening and second, a forward citation tracking in Google Scholar to see if any further commentaries had been published in response.

Position statements: I gathered stakeholder position statements from stakeholders' respective websites. I searched the websites of Canadian organizations that were likely to have a vested interest in MMS, such as the Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), the Canadian Psychiatric Association (CPA) and Dying With Dignity Canada (DWDC), for position statements on recent MAiD developments. Following Nicolini et al. (2020), who maintain that "responding to an argument implies taking a position" (p. 1243), I also included stakeholder responses to position statements in my dataset.

After collecting an initial dataset, I performed a reading through sets of documents written by the same author to simultaneously reduce the overall number of texts and eliminate redundancy in my analysis. For example, in my initial assemblage, there were ten documents written by Dr. Sonu Gaind. Several of these articles presented similar or identical arguments and thus, four of them were removed. Given that several search strategies were required and that filtering for 'expert' authors had to be done manually, that is, using a Google search to determine the author's credentials, the process of gathering and finalizing the dataset took approximately four weeks. I retained 80 documents for analysis: 37 news and magazine articles, 20 commentaries, and 22 position statements (see Appendix C). This is an appropriate number of articles given the scope of ECA and the number of articles used in previous ECA studies (Altheide & Schneider, 2013).

2.2.3 Stage 3 - Data Coding and Organization

Following Altheide and Schneider (2013), step eight of my project involved an initial reading of the dataset and coding. I read each document for its content and noted common ideas, themes, words, phrases, and discursive strategies that I felt warranted further analysis. This allowed me to identify significant traits and tensions in the data and to begin theorizing themes, frames, and discourses. After familiarizing myself with the dataset through this initial reading, due to the enormity of data, I decided to make use of a data management software. I imported my dataset into NVivo for storage and organizational purposes. I used the software primarily as a means of organizing my data, to broadly code arguments deployed in the debate, and to help track any early insights and decision-making processes, rather than for its analytical capabilities. After configuring NVivo, I began a second reading of the dataset.

During the second, more thorough reading of the dataset, I used the first protocol sheet (see Appendix A), to record the document's title, source, publication date, author's name and credentials, the position taken on MMS, the arguments used to support that position, a summary of the document, and any other miscellaneous insights. After completing a protocol sheet for every document, I compiled the extracted arguments into a master list, noting a few descriptive examples and direct quotes for each one. I then reviewed the master list and collapsed arguments into broad subframes to form a codebook. For the purposes of my study, coding played only a preliminary role in my analysis, to help familiarize myself with the dominant arguments and to classify the data in preparation for the deeper level of analysis to follow.

I then added the subframes as codes into NVivo and applied the codes to each document. For example, a newspaper article entitled "MAID for mental illness: Why safeguards won't work" (Maher, 2020c) presented several arguments against MMS including that people with mental illness do not have full or timely access to effective mental health treatments and that patients with mental illness are already free to kill themselves without help from the health system. These arguments were assigned to the subframes "vulnerability" and "suicide", respectively. Coding in this way allowed me to see any lines of argumentation that were missed in my initial readings, as in, any arguments that did not fit into one of the existing subframes. Applying the subframes to the documents also enabled me to track the frequency of arguments and to investigate which arguments played more dominant or marginal roles in the expert debate, thus setting the stage for a more nuanced analysis.

2.2.4 Stage 4 - Data Analysis

The ninth step in ECA is data analysis, with the goal of identifying themes, frames, and discourses (Altheide & Schneider, 2013). Steps one through eight contributed to ongoing analysis, however, step nine entailed a more intensive examination of the textual and contextual data. To facilitate a critical reading of the documents during this stage, I integrated Carvalho's (2008) framework for discourse analysis. This framework aligns with ECA because it can be easily incorporated into a protocol sheet (see Appendix B) and uses the constant comparison method touted by ECA scholars (Altheide & Schneider, 2013) and other qualitative analysts (Bernard, 2017).

Carvalho (2008) recommends approaching analysis in two stages. The first stage involves the analysis of the six dimensions of a text that "matter the most in the construction of meaning" (Carvalho, 2008, p. 167). How these six dimensions were used in this study is described below.

1. *Layout and structural organization:* These included the headline/title, the date the document was published, the length of the document, and so on. For example, the title, "MAID is cheaper than caring", of a 2022 op-ed article by John Maher has important implications for the audience's perception of the issue. It marks the preferred reading of the article and negatively portrays MAiD by implying that it does not constitute an act of care while simultaneously insinuating that there may be economic motives driving the implementation of the practice in Canada.

2. *Objects:* Objects can be likened to topics or themes (Carvalho, 2008). In my study, examples of broader objects include MAiD, mental illness, psychiatry, and suicide. Examples of more specific objects that emerged included psychiatry's role in MAiD, decision-making capacity in mental illness and evidence-based care. Objects can also be the links or relationships that authors create between phenomena (Carvalho, 2008). For instance, throughout the documents, shifting MAiD eligibility is consistently linked to an inadequate mental healthcare system.

3. *Actors:* This element is concerned with the individuals or institutions that the document refers to and how they are represented (Carvalho, 2008). In addition to identifying individual actors mentioned throughout the documents such as other experts, the Government, psychiatry, and other jurisdictions like Belgium and the Netherlands, I classified landmark court cases, like *Truchon* and *Carter* as actors in my analysis. I also recorded how people with mental illness were depicted.

4. *Language, grammar, and rhetoric:* Unlike detailed linguistic analysis, Carvalho's (2008) framework is not concerned with issues of pragmatics, semantics, and syntax. In my analysis, I paid close attention to how key concepts – like vulnerability, suffering, capacity, and discrimination – were used to advance various positions on MMS, how chosen vocabulary constructed objects like mental illness, and how authors supported their arguments whether that be through emotionally charged anecdotes or scientific data.

5. *Discursive strategies*: For this study, I mainly considered the strategies of framing, positioning, (de)legitimizing and constructing responsibility and how the adoption of these strategies enabled or constrained certain discourses. For instance, some authors used the language of treatment and care to support their position, thus adopting a medical framing of this issue. Others discussed MMS in terms of rights, thus framing it as a legal issue.

6. *Ideological standpoints:* Ideology is an overarching aspect that is embedded within the previous five elements and is arguably the most fundamental shaping influence of a text (Carvalho, 2008). Sometimes an author's ideological standpoint is explicit and other times it must be inferred from the abovementioned elements (Carvalho, 2008). Recording each author's ideological standpoint enabled me to recognize that although the arguments informing the debate are commonly presented in a binary fashion, there are alternative perspectives that inhabit a more nuanced middle ground. Experts engaging with the issue of MMS lie on a spectrum from the position that MAiD should never, under any circumstance - including physical, terminal illness - be offered to anyone, to the position that MAiD should be an option available to everyone, even those without a diagnosed medical condition.

The second stage in Carvalho's (2008) framework moves beyond individual documents to the overall coverage of an issue and examines the wider social context. Two time-related dimensions of analysis are considered at this stage – synchronic and diachronic – and are achieved by two means of inquiry, comparative and historical analysis, respectively (Carvalho, 2008). Carvalho (2008) describes comparative-synchronic analysis as looking at various representations of an issue by comparing texts published around the same time. This strategy is inherently built into the constant comparison method of ECA and the inclusion criteria for the documents I reviewed. Historical-diachronic analysis means examining the course of social issues and the temporal evolution of discourses (Carvalho, 2008). For this study, this involved looking at the sequence of discursive constructions of MMS and asking questions like: How did this representation of MMS impact on subsequent ones? How was it reproduced or contested in subsequent publications? What are the social and/or cultural implications of the dominant discourses? Exploring intertextuality by investigating the links between documents allowed me to discern alternate constructions of the issue and distinguish dominant discourses as well as to examine what emergent discourses revealed about larger socio-cultural understandings of mental illness and psychiatry.

Steps ten and eleven involve the sorting and categorization of data (Altheide & Schneider, 2013). I began by revising and comparing protocol sheets to illuminate similarities, differences, and "extremes" within each protocol category and reviewed the coded data (subframes) for each document. The recursive process of comparison eventually led to the generation of five discourses embedded within two overarching frames – legal rights and clinical ethics. At this stage, I wrote summaries about each one, which included potential sub-discourses, my interpretations, and early analytic insights. After revisiting my data to confirm my preliminary analysis, I solidified the frames and discourses that would eventually form the basis and structure for Chapters Three and Four of this thesis.

2.2.5 Stage 5 – Report

The fifth and final stage of ECA, step twelve, is to report the research findings (Altheide & Schneider, 2013). During this final step, I focused on describing the different discourses that emerged from my analysis, incorporating quotations to support my research conclusions, and connecting my findings to relevant literature to answer my research questions. As an analytic and writing strategy, I chose to discuss discourses independently. However, all discourses overlap and mutually inform one another. To illustrate this interconnection and how themes, frames, and discourses are co-constructed to give meaning to each other, the concluding chapter of this thesis summarizes and consolidates my interpretations.

2.3 Limitations

I conclude this chapter by acknowledging some limitations of this study. Given that I was the only person working on this project, one limitation of this study was the lack of intercoder reliability. There is no way of knowing whether another researcher would have coded the same arguments, elicited the same discourses, or consolidated the same overarching frames. To improve reliability, I compared my findings to existing studies examining arguments around assisted dying for mental illness (see, for example, Grassi et al., 2022; Nicolini et al., 2020).

My study was also limited by my definition of who constitutes an “expert”. Healthcare providers, lawyers, and scholars engaged with MAiD discourse regularly publish on the topic and speak before the House of Commons, and thus play a significant role in constructing the Canadian debate. However, there are other voices who possess a wealth of expertise that are missing from my sample. Some of these key voices include, for example, journalists, politicians, economists, and people with lived experience of mental illness. Including documents produced by a wider variety of experts could have provided more diverse and alternative perspectives on the issue of MMS.

Another limitation was that I only analyzed documents written in English. In the context of assisted dying, the only Canadian province that is primarily francophone is unique in that MAiD in Québec is subject to the federal *Criminal Code* but also to the provincial *An Act Respecting End of Life Care.* There are inconsistencies between the federal law and the Quebec legislation, and it is unclear whether Quebec legislation will be amended to align with federal jurisprudence. In December 2021, Quebec's commission on MAiD, *la Commission spéciale sur l'évolution de la loi concernant les soins fins de vie*, recommended not expanding access to MAID for people whose only medical problem is a mental illness (Assemblée Nationale du Québec, 2021). Thus, it is possible that there are alternative messages and discourses conveyed through French documents concerning MMS.

Despite my best efforts to remain highly reflective and bracket my biases throughout the research process by writing memos and journaling, I recognize that I speak from a particular subject position, informed by my own experiences with and understandings of death and mental illness. Thus, another researcher with a different perspective on the issue, might draw different interpretations than my own about this morally charged debate. It is crucial to reiterate that I do not seek to advance a moral position on whether assisted dying for those suffering solely from mental illness is right or wrong. Rather, with this thesis, I aim to articulate how arguments for or against MMS are constructed by experts from a variety of relevant fields and to explore what this contentious debate reveals about contemporary conceptualizations of mental illness.

CHAPTER 3: LEGAL RIGHTS-BASED DISCOURSES

Canada is a pluralist liberal democracy, and as such, discourses surrounding ethically contentious legislation are generally “guided by values over which there is some significant degree of consensus within Canadian society” (Schüklenk et al., 2011, p. 29). According to Schüklenk et al., (2011), these values can be identified by looking to the ethical cornerstones of Canada’s institutional order, a particularly rich source of which is the Canadian Charter of Rights and Freedoms. Indeed, rights rhetoric has long permeated assisted dying movements, with ‘right-to-die’ organizations becoming politically active in the 1930s in the United Kingdom and the United States (Blouin et al., 2022) and in 1991 in Canada (Crumley et al., 2019). Assisted dying in Canada has since been defined by judicial decisions informed by rights-based arguments. In fact, central to MAiD’s discursive history are the conflicting discourses of a ‘right to die’ as signifying the ideal of bodily autonomy and the ‘right to live’ as promoting the sanctity of life (Rhodes, 1998). Unsurprisingly, my study found rights-based discourses to be integral to the expert debate on MMS.

Echoing pre-decriminalization deliberations, individuals and organizations have been quick to frame their arguments for and against MMS in terms of rights, presumably “attracted by the trumping and attention-getting effects of rights discourse and the powerful political impact of rights-based arguments” (Lewis, 2007, p. 15). Proponents and opponents of the proposed changes to Canadian law have claimed a number of rights to support their respective positions, many of which have been used in previous constitutional challenges (Lewis, 2007). Notably, section 7 – the right to life, liberty, and security of the person – and section 15 – equality rights – of the Charter were critical to the success of the

Truchon case (Downie, 2022). In their review of representations of MAiD in Canadian news media, Brassolotto et al. (2022) found conflicting rights claims between the opposing voices of the debate. Comparably, across the documents that I reviewed, experts invoked the same Charter rights to champion conflicting policy demands.

In this chapter, I demonstrate how experts across my dataset constructed MMS as either an exercise or violation of rights and consider what rights-based discourses and their constituent arguments reveal about contemporary understandings of mental illness and suffering. My analysis is structured around three main themes that featured prominently across my dataset: autonomy, vulnerability, and equality. I describe the arguments related to these themes and explore how the endeavor to balance autonomy, protection, and equality takes on renewed significance in the MMS debate.

Couched in the language of rights, experts engage with norms, assumptions, and values that not only shape and reflect their conceptions of mental illness but also have larger cultural consequences that seep into how we define and respond to mental suffering. I argue that experts' position on MMS depends, at least in part, on their understanding of mental suffering. Furthermore, I contend that the extreme polarization among experts highlights an enduring contentiousness around mental illness as a biomedical category and perhaps reflects a larger trend toward a reconceptualization of mental illness, one that challenges the dominant medical model.

3.1 The Right to Choose

Alongside the development of liberal democracies and the influence of neoliberalism, Canadian medical ethics and law adopted autonomy as a guiding principle.

In medical practice, autonomy is often described as the right of competent adults to make informed decisions about their own medical care and treatment (Varelius, 2006). In the Canadian healthcare system, the value ascribed to autonomy is perhaps most apparent in the right afforded to competent patients to refuse medical treatment or interventions, however grave the consequence of doing so may be (Canadian Medical Protective Association, 2023). Given the value ascribed to autonomy within healthcare ethics and law, it is no surprise that it plays a dominant role in the discourses and decisions surrounding a contentious medical intervention.

The concept of autonomy has been central to assisted dying rhetoric and judicial decisions about MAiD. Several social scientists have identified choice and autonomy as prerequisites for a good death and as critical to the assisted dying ethos (Buchbinder, 2021; Gandsman, 2018; Norwood, 2020). Likewise, the Court concluded in *Carter* that the prohibition of assisted dying unjustifiably infringed upon section 7 of the Charter: the constitutional provision that guarantees personal autonomy to Canadians (Government of Canada, 2022). Across my dataset, autonomy-based arguments were especially divisive, and often referred to the history of paternalistic treatment in psychiatry.

In the first half of the twentieth century, asylums granted psychiatrists the power to compulsorily confine and treat people with mental illness (Busfield, 2014; Rose, 2018). In response, the 1960s saw a rise in anti-psychiatry movements and a subsequent push for deinstitutionalization (Busfield, 2014). Since then, empowerment movements have fought to privilege the voice of the patient in the mental healthcare system (Busfield, 2014; Coleman, 2008; Rose, 2018). Despite widespread reform of legal regulations and institutional mental healthcare practices in recent decades, overriding patient autonomy remains common practice in psychiatry and is usually accomplished by way of coercion, compulsion and/or involuntary treatment in the name of beneficence (Rose, 2018). Such practices continue to come under intense scrutiny by critics like Kolar et al. (2022) who argue that discourses of protection discount patient preferences and unjustly construct them as "passive recipients of care" (p. 8) who lack agency to engage in decision-making about their own medical treatment, thus denying their rights to autonomy. Within the documents that I reviewed, there was dissensus among experts about whether the option of MAiD would promote or undermine autonomous choice for patients with mental illness.

3.1.1 Autonomous Choice

Advocates of assisted dying have long framed the issue as an individual's 'right' to address their suffering and to control the circumstances of their own death (Buchbinder, 2021; Gandsman, 2018). Many scholars have explicitly examined autonomy arguments for assisted dying in the end-of-life context (see Braun, 2022; Gandsman, 2018; Hannig, 2019; Sjöstrand et al., 2013), but there is far less exploration of autonomy in the context of MMS. The notion of autonomous choice was pervasive among proponents of the practice and emerged as a prevailing discourse in the documents I reviewed. Through *the autonomous choice* discourse, experts constructed MMS as an autonomous, rational person's choice and as a progressive human right - to autonomy and self-determination - for people with mental illness.

Experts – typically proponents – framed the exclusion of mental illness from MAiD as reflecting a higher, yet unwarranted, tolerance for denying the right to personal autonomy to people with mental illness compared to other medical conditions. As per one legal expert, “the basic human right to autonomy, self-determination and control over one’s own body and one’s own fate is just as important and central to those dealing with mental illness as all others, assuming such a dichotomy even exists” (Bay, 2017, p. 3). This excerpt not only depicts assisted dying as an essential human right that ought to be afforded to people with mental illness, but also questions the often-purported distinction between mental and physical illness conditions. Similar concerns were echoed by other experts across my dataset, who condemned the prohibition on assisted dying as a form of legal paternalism and argued that excluding people with mental illness from MAiD unjustly strips a large and diverse group of people of their autonomy, thus violating their Charter rights:

> It is unjustifiable to exclude psychiatric patients from benefitting from a medical intervention that is designed to preserve autonomy. (Dembo et al., 2018, p. 454)
>
> [Proponents of restrictive access regimes] essentially advocate to remove such patients’ agency, because they disapprove of the end-of-life choice that some of these patients would predictably make. The kind of strong paternalism – well intentioned as it may be – that is on display here must be placed where it belongs, in a long tradition of views of disability and mental illness that renders such patients less able than others to make decisions about their own lives…They sacrifice patient rights on the altar of their paternalistic values. (Downie & Schüklenk, 2021, p. 666)

The quotes above portray MAiD as a medical intervention that would both protect and promote the right to autonomy and self-determination for patients with mental illness. The second quote explicitly situates a denial of such rights within the history of paternalism in psychiatric care. Both excerpts exemplify how some experts across my dataset used autonomy-based rhetoric, and its opposite, paternalism, to advocate for the legalization of MMS.

In the documents that I reviewed, autonomy arguments often hinged on experts' beliefs about what scholars Bergamin et al. (2022) refer to as one of the main 'dimensions' or 'pillars' of autonomy: decision-making capacity (otherwise known as competency). Decision-making capacity is one of the primary safeguards embedded in Canadian MAiD law. To be considered eligible for MAiD, a MAiD assessor must determine that the person requesting assisted death has capacity to make healthcare decisions (Government of Canada, 2023).

Across my dataset, the decisional capacity of patients with mental illness was questioned by some expert opponents.[11] For example, in a commentary for the *Canadian Medical Association Journal*, two researchers stated a "concern that some patients who request assisted dying because of a psychiatric illness may not meet the criteria for mental capacity" (Kim & Lemmens, 2016, p. E338). Likewise, in a 2016 article for the *Ottawa Citizen*, two psychiatrists made the claim that "patients with depression are inherently incapable of making a competent request for euthanasia. It is wrong to ignore the effect depression can have on a person's cognition." (Lau & Fernandez, 2016, para. 4). Their statement can be read as simultaneously equating depression with irrationality and invalidating depressed patients' requests to die by attributing them to mental illness. They question whether a decision about death can be rationally made by a person with a mental illness. By linking irrationality to mental illness, these experts suggest that mental illnesses make people irrational (e.g., produce cognitive distortions). Moreover, some experts' statements about incapacity reflected and supported a biochemical understanding of mental

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[11] Experts also questioned whether doctors, especially psychiatrists, can reliably assess capacity in patients with mental illness (see Charland et al., 2016; Kim & Lemmens, 2016; Maher, 2016). I address this issue and others surrounding the discipline of psychiatry and mental healthcare in chapter Four.

illness. For example, one psychiatrist implied that with mental illness, a person's "brain isn't working as it usually does" (Maher, 2016, p. 2). Blanket statements like this support what philosophers Craigie and Bortolotti (2014) describe as the 'status approach' which holds that psychiatric diagnosis alone eliminates the need to assess a person's capacity because mental illness automatically denotes irrationality and/or impaired cognition.

By contrast, many proponents rejected the 'status approach' (Craigie & Bortolotti, 2014) and voiced concerns that to exclude all individual requesting MAiD for mental illness falsely implies that everyone in that category lacks capacity. To rebut the oppositions concerns, one psychiatrist claimed that while capacity issues are built-in to MAiD processes, they are not unique to situations of mental illness:

> This is a problem inherent to permitting medical aid in dying. Excluding patients with psychiatric disorders changes neither the uncertainty nor the normativity involved in defining and assessing capacity. It does restrict the population of people who can access this practice although it is not clear from what the authors have presented that all people with psychiatric disorders ought to be judged incapable of deciding whether to receive medical aid in dying. (Gupta, 2016b, p. 3)

This excerpt refutes the argument that mental illness automatically deprives someone of the decision-making capacity necessary for an assisted death and makes this claim on the basis that concerns around capacity apply to all situations of MAiD, not only MMS. Several proponents argued that to adhere to the Charter and respect Canadians' rights to autonomy, capacity in all assisted dying evaluations must be assessed on a case-by-case basis, and not, as Gupta and Downie (2022) write: "expressly rejected blanket exclusions on the basis of membership in a group" (para. 3). Moreover, some proponents emphasized that capacity does not exclude people with mental illness from other rights embedded in the Canada Health Act. For example, in a short piece for *Impact Ethics*, one legal expert reminded readers that people with mental illness "routinely make life and death medical decisions, including whether to forego medical treatment or life-sustaining measures. In such cases, physicians assess capacity and can do the same for patients who request medical assistance in dying" (Tanner, 2017, para. 3).

Through the *autonomous choice* discourse, expert proponents constructed MAiD as a basic human right for patients with capacity who suffer intolerably due to a medical condition, including mental illness. They rejected the claim that mental illness precludes autonomous choice and depicted the exclusion of mental illness from MAiD as unconstitutional and based on erroneous assumptions of incapacity. Moreover, experts portrayed the autonomy granted from access to MAiD as especially important for patients with mental illness because they constitute a category of people that, for decades, have been denied the right to exercise their self-determination in clinical settings. Ultimately, this discourse posits that people with mental illness should have the same rights to autonomy – and thus the same options to alleviate their suffering – as people with other (physical) medical conditions. From this perspective, excluding people with mental illness from MAiD violates their human right to autonomy, and risks discriminating - or dehumanizing - Canadians with mental illness. Not all experts, however, agreed that MMS would promote autonomy for people with mental illness.

3.1.2 Privileged Autonomy

Across my dataset, a recurring argument for restricting access to MAiD was that rights-based advocacy is built upon fallacies or illusions of autonomy. The *privileged autonomy* discourse, named after a concept invoked by a psychiatrist in my dataset (Gaind, 2021a; 2022), defends the position that MAiD can never be an autonomous choice for people with mental illness because their request to die is a product of social inequities, stigma, and discrimination rather than of their own free will. For example, in an editorial for the *Journal of Ethics in Mental Health,* one psychiatrist questioned whether allowing access to MAiD for people with mental illness qualifies "as fostering their autonomy or giving them a push towards death?" (Maher, 2017, p. 1). Accordingly, some experts shared the perspective that allowing MAiD outside end-of-life contexts thus enhances only a particular kind of autonomy – *privileged autonomy* – at the expense of the marginalized.

Across the documents I reviewed, psychiatrist and past CPA president Dr. Sonu Gaind was among the most outspoken about the potential impact of MMS on autonomy and health outcomes for marginalized populations. In an opinion article for the *National Observer,* Gaind (2022) described MAiD expansion as a "tale of two worlds. The same law, but different impacts on different groups" (para. 15). He has elsewhere elaborated on this concern, expressing that while MMS might enhance the autonomy of the white, wealthy, and privileged, it will sacrifice the most vulnerable – including, those with mental illness – to entirely avoidable premature deaths (Gaind, 2021a, 2021b). He contrasted data showing that currently in Canada, those who seek MAiD tend to be more privileged, that is, those who "already live well and will have more autonomy to die better" (Gaind, 2021a, para. 13) with evidence from the Benelux – where psychiatric assisted dying is permitted - which shows that people marginalized by poverty, loneliness and unresolved suffering seek aid in dying. Gaind (2021a) highlights this contrast to argue that once nonterminal conditions become eligible for MAiD in Canada, the target demographic is likely to shift from the privileged to the marginalized.

The notion that support for MMS comes from both a position of privilege and benefits the privileged was echoed by several experts in the documents that I reviewed. Notably, in a statement to the CPA, Indigenous leaders and representatives from across the country argued that by failing to address the risks of suicide to Indigenous communities and existing mental health inequities in their position statement on MMS, the CPA "provides recommendations that continue policies of privilege" (Nicholas et al, 2021, p. 1). Likewise, in an article for the *National Post*, one doctor stated that "those terminal patients who've lived a good life and have the privileged autonomy to choose a "good" death are overwhelmingly white and affluent. Unfortunately, their rights magnify the vulnerability of those who've never had a good shot at life" (Faruqui, 2022, para. 38). From this perspective, the option of MMS only enhances autonomy rights for an already privileged population, while further magnifying the vulnerabilities of those with mental illness. The idea of "privileged autonomy" can be found in the literature, though not by the same name, by social science scholars who argue that promoting assisted dying under the assumption that everyone deserves the same right to control their death fails to consider structural and cultural constraints (Buchbinder, 2021; Norwood, 2020; Pasman et al., 2009; Stavrianakis, 2020).

In their submission to the *Journal of Ethics and Mental Health*, experts Charland et al., (2016) cautioned that judicial decisions about MAiD are subject to societal and cultural pressures, including, "notably, a cultural bias in favor of autonomy" (p. 7). As demonstrated above, other experts echoed their concerns and challenged the widespread acceptance of autonomy-driven right-to-die rhetoric, arguing that there are limits to respecting autonomous choice, even in liberal democracies. Ultimately, the *privileged* *autonomy* discourse calls attention to a need to balance autonomy as a fundamental right against its consequences, which in the case of MAiD, is an irreversible intervention: death. Experts' – mostly opponents - concerns about Canada's commitment to autonomy in the context of MAiD can be succinctly summed up by an excerpt from Charland et al. (2016), who assert that: "an overly zealous commitment to autonomy and individualism at all costs, make us worry whether autonomy may actually be turning on its own and is poised to devour its most vulnerable subjects" (p. 10).

3.2 The Right to Adequate Healthcare and Social Supports

Appearing in over half of the documents that I reviewed, one of the most popular concepts invoked by experts in my dataset was vulnerability. It is unsurprising that vulnerability is a dominant theme in the expert debate considering that Canada's obligation to protect vulnerable people with respect to assisted dying is emphasized in a set of recommendations known as the Vulnerable Persons Standard (VPS). In 2016, key stakeholders from across the country developed the VPS to act as a guide for legislative representatives who would be drafting MAiD-related laws (VPS, 2022). It suggests a series of safeguards intended to balance access to MAiD with the need to protect those whose social vulnerability might motivate their request to die (VPS, 2022). In the context of MAiD, vulnerability is typically used to refer to the "exploitation or coercion that individuals from marginalized groups may experience in light of social inequities" (Brassolotto et al., 2022, p. 171).

In the documents I reviewed, vulnerability-based arguments were often made with either explicit or implicit reference to rights. Specifically, experts drew upon the right to adequate healthcare and social supports for people with mental illness to bolster their respective positions on MMS. Most experts agreed that access to mental healthcare and social supports needs to be improved for people with mental illness. Where they differed, however, was in their opinion on whether existing access issues justify a continued prohibition of MAiD for all individuals with mental illness and how the implementation of MMS would impact patients' rights to healthcare and social supports. Some experts – primarily opponents - argued that the Government might see the option of MAiD as a replacement for healthcare and social supports, thus undermining patients' rights to adequate care. Others – mostly proponents - oppositely maintained that MMS and mental health services are not mutually exclusive, and argued that allowing MMS could ironically promote access to care and support by increasing access to medical resources (e.g., psychiatrists) and fostering safe spaces to discuss the desire to die. Comparative analysis revealed dissensus among experts about the relationship between vulnerability, mental illness, and MMS which subsequently revealed diverse interpretations of mental suffering.

3.2.1 Protect the Vulnerable

Vulnerability-based arguments are routinely used to inform and justify mental health legislation across the country, including involuntary hospitalisation (Kolar et al., 2022). In their provocative contribution to suicide scholarship, Baril (2017) argues that discourses of protection assume that if people are not at the end of life with a medical condition, "their request to die must be an expression of their vulnerability" (p. 205) and thus, is considered an illegitimate desire to die. They maintain that suicidal people are constructed as illegitimate subjects who must be kept alive by Canadian legal and medical systems (Baril, 2017). Indeed, in the documents that I reviewed, one of the most widely accepted arguments in favor of the ban on MMS was that doing so would *protect the vulnerable*. Expert opponents portrayed people with mental illness as exceptionally vulnerable compared to others who might seek MAiD, namely, those with physical and terminal medical conditions. Their vulnerability was predominantly depicted as contingent on broader social factors. Consequently, some of these experts' understandings of mental suffering appeared to transcend biomedical explanations.

To be eligible for MAiD, a person must have suffering that originates from a "grievous and irremediable medical condition" (Government of Canada, 2023). Given that MAiD is a medical procedure and exists within a biomedical framework, it is reasonably interpreted that any condition to which it is applied should also fit into a biomedical paradigm. Considering there are plenty of commentators who question whether mental illness should be considered a medical problem (see Rose, 2018; Szasz, 2007), it is easy to see how MAiD eligibility becomes arguably more complicated in the context of mental suffering than in cases of physical illness. My study found that experts' beliefs about the roots of mental illness partially informed what they determined to be an appropriate solution to mental suffering, and whether they endorsed MMS.

During the *Truchon* era debates over whether to remove the reasonably foreseeable natural death clause from MAiD requirements, arguments based on the social determinants of health - the economic and social conditions that influence differences in health status – gained notable prominence (Downie & Schüklenk, 2021). Correspondingly, in the documents I reviewed, many experts believed that patients with mental illness should not be eligible for assisted dying because their request to die may not be a consequence of direct illness-related suffering, but rather of poor social determinants of mental health. Specifically, experts cited concerns about the role played by socioeconomic factors, such as inadequate income support, underemployment, lack of housing, and inadequate access to mental healthcare in mental suffering and requests for MAiD:

> Offering MAID as a cure for mental illness reduces any incentive to improve mental-health supports and treatments… Rather than offering people a way to die, we must provide the supports they need to live. (Zekveld, 2022, para. 7)
>
> My problem is whether much seemingly irremediable suffering in the case of those with mental illness is caused by our disjointed and underfunded system as well as a society that is persistently hostile to this population. (Bay, 2017, p. 1)
>
> Social isolation, underemployment, poverty or lack of housing all have an impact on the suffering from mental illness. (Gaind, 2016, para. 11)

Common across the extracts above is the concern that people's mental suffering, and consequently their desire to die, may arise not due to their mental illness directly, but rather due to poor social and economic determinants of health and a lack of any reasonable alternatives to help alleviate their suffering or support their ability to live. Indeed, expert opponents cautioned that should it become legal, MMS would "become the answer for resolvable life suffering" (Gaind, 2022, para. 17) and "give people with mental illness a legal impetus to see MAiD as a solution to socially inflicted suffering" (Kaiser et al., 2021, para. 7) in place of proper treatment and social support.

The worry that increasingly liberal assisted dying laws would further undermine funding for social services and mental healthcare was widely expressed among the opposition. Considering ongoing mental health crises and the current state of mental healthcare in Canada, some experts argued that we should not consider implementing MMS until we have addressed health inequities and disparities in healthcare:

> No one in this country should ask for MAiD if they can’t get the social and medical supports they need” (Faruqui, 2022, para. 83)
>
> What about addressing the social determinants of mental health? Are those crucial issues going to be remediated by the government before a new law comes into effect? (Vrakas, 2020, para. 8)
>
> Governments at all levels must first and foremost improve access to quality mental health care as well as the social supports needed by the most vulnerable to recover their mental health. (CAMH, 2016, para. 2)
>
> …it may be premature to begin providing MAiD for those with mental illness when there is simply so much work for Canada to do when it comes to improving mental health care. (Mahendiran, 2021, para. 9)

Here, experts constructed a mutually exclusive relationship between MAiD, mental healthcare, and social support services. In other words, the *protect the vulnerable* discourse urges legislators to address social and health inequities *before* legalizing MMS, not simultaneously. Without first offering adequate social supports and/or treatment options, experts warned that patients’ requests to die would not constitute a “real” choice for people with mental illness. From this perspective, while mental illness itself plays a minor role in motivating requests to die, Canada’s inadequate social and mental health system enhances patients’ vulnerability and acts as a primary driving force behind a person’s MAiD request.

Discourses of protection also relied heavily on what are commonly referred to as “slippery slope” arguments. Experts across my dataset not only used the term “slippery slope” explicitly, but also used metaphors such as “runaway train” (Bird, 2022), “pandora’s box”(Vrakas, 2019), and “falling off a cliff” (Gaind, 2022) to construct MMS as a perilous practice that has all too quickly transformed from a last-resort option for those with end-stage disease to an everyday treatment option with a rampant potential for abuse.

Since Canadian legislation does not require that a patient exhaust all treatment options prior to requesting and/or receiving MAiD, there is widespread concern that permitting assisted dying on the grounds of mental illness leaves patients vulnerable to undue influence, external pressure, and coercion. Experts across my dataset warned that if Canada allows assisted dying for mental suffering, people will request and receive MAiD due to pressure or coercion from family, physicians, society, their socio-economic circumstances, and so on. For example, one psychiatrist argued that "it is inevitable that health professionals, probably unconsciously most or all of the time, will influence patients considering assisting dying in a way that is likely to free up scarce but much needed resources like beds" (Bay, 2017, p. 6). A group of legal professionals similarly raised concerns about pressure to die stemming from a lack of accessible care: "MAID is uniformly covered by the health care system; supports, on the other hand, are often expensive, require lengthy waits — sometimes years — and are thus largely inaccessible to many" (Kaiser et al., 2021, para. 9). Ultimately, these experts argued against MMS in the name of protecting the more vulnerable – patients with mental illness - from varying forms of undue influence toward death.

The vulnerability-based concerns described above are not novel to the discussion around mental illness. In my dataset, one law professor argued that hundreds of people with physical illness conditions have likely chosen MAiD because of inadequate healthcare: "it is fair to surmise that many of the thousands of Canadians who have already chosen euthanasia did so because they felt they had no other realistic way to manage their pain and suffering" (Bird, 2022, para. 8). Similar points have been made in an extensive body of literature that considers the issue of vulnerability and persons with disability in relation to assisted dying and of MAiD as an alternative to, or substituted for, appropriate disability supports (see Mwaria, 1997; Scoccia, 2020; Stainton, 2019). Although these concerns may not originate from the debate around MMS, I maintain that they are amplified in the context of mental illness because of its strong association to poor socio-economic conditions:

> People with mental disorders are more likely to live in precarious social and economic circumstances—for example, to be poor, unemployed or homeless. They are more isolated, left to their own devices, with no meaningful support network. They are sometimes marginalized and are often either incarcerated or institutionalized. (*Ordre des Psychologues du Québec*, 2020, p. 11)
>
> Research suggests an obvious interplay of social determinants of health and psychosocial flavour to mental illness. Specifically, Canadians with mental illness are less likely to have primary care physicians. Moreover, many Canadians commonly experience wait times of 6-12 months for mental health counselling and specialty psychiatric hospital services. Many provincial health insurance plans and public drug plans do not cover the latest medications and psychotherapy. (Mahendiran, 2022, para. 8)
>
> We know that especially in mental illnesses, psychosocial factors significantly contribute to suffering. Social isolation, poverty, inadequate housing, and under or unemployment compound suffering from mental illnesses. (Gaind, 2020, p. 604)
>
> Evidence also shows that, unlike MAID for physical illnesses, more socially vulnerable people seek MAID for mental illness (Gaind & Tang, 2021, para. 3)

In these excerpts, experts distinguished mental illness from other medical conditions by its relationship to poor social determinants of health. As per Downie and Schüklenk (2021), on these arguments, “a person with mental illness asking for an assisted death is merely an indication of a healthcare system failing the needs of that patient” (p. 665), rather than of unbearable or intolerable medical suffering.

The *protect the vulnerable* discourse constructed MMS as a dangerous risk to Canadians with mental illness and as a violation of their rights to protection, adequate healthcare, and social support services. Experts employed the language of vulnerability vehemently to argue against MMS. They described inadequate care and support as a source of vulnerability for people with mental illness and portrayed people with mental illness as inherently more vulnerable than those with other medical conditions. Drawing on social determinants of health and "slippery slope" arguments, experts alluded that unbearable suffering in mental illness does not necessarily stem from the condition itself, rather, it is socio-structural issues that cultivate intolerable mental suffering and thus motivate requests to die. As queried by one staunch opponent, if we legalize MMS, is it an indication that we accept "society's "failure [as a] legitimate source of intolerable suffering?" (Maher, 2016, p. 4). Experts advocating to protect the vulnerable maintained that rather than implementing MMS, Canada must confront the (social) roots of suffering and lack of support for people with mental illness. Given the value ascribed to the social dimensions of suffering by expert opponents across my dataset, I contend that those who advocate to *protect the vulnerable* by prohibiting MMS reject a purely biomedical view of mental illness.

3.2.2 Rejecting Inherent Vulnerability

In contrast to the arguments described above, there were also experts who argued that the possibility of heightened vulnerability is *not* a sufficient justification for a blanket prohibition on MAiD for mental illness. Such experts did not deny the fact that people with mental illness have been shown to have poorer social conditions nor that Canada must work toward improving social supports and care for people experiencing mental suffering. However, they argued that social vulnerability is not an adequate rationale for denying MAiD to a diverse and heterogenous population and more importantly, that vulnerability is not unique to people with mental illness. Moreover, several experts maintained that assisted dying and improved care/support are not mutually exclusive; that the option of MMS might promote, rather than violate, patients' rights to adequate healthcare and social supports.

In *Truchon*, the Court agreed that the broad protection that results from the concept of collective vulnerability is "too general an application of a precautionary principle" (Downie & Schüklenk, 2021, p. 666). Likewise, in the documents I reviewed, many expert proponents argued that vulnerability, like capacity, should not be defined by a person's belonging to a certain group, but rather assessed on a case-by-case basis. They asserted that social vulnerabilities are not unique to people whose sole condition is mental illness and as such, that these patients should be treated the same as any other MAiD requester:

> I am dismayed at recent commentary that suggests persons with mental illness should not be permitted to exercise their autonomy because they are more vulnerable than persons with physical illness. This implies that they should not be permitted to decide for themselves how much suffering is too much. It also implies that persons *without* mental illness are always less vulnerable. But severe pain, nausea and existential suffering toward the end of life can also lead to vulnerability. (Dembo, 2020, para. 4)
>
> The recommendation [to not expand access to MAiD for people whose only medical problem is a mental disorder] ignores the vulnerabilities of some people, such as those experiencing serious socioeconomic disadvantage who have physical disease. (Gupta & Downie, 2022, para. 16)
>
> We are asked to ignore their requests and so protect their vulnerable selves and their human rights. Of course, anyone suffering tremendously from a disease or condition that renders their lives not worth living finds themselves in a position of vulnerability. That is true regardless of whether one suffers from late-stage cancer or treatment-resistant depression. (Schüklenk, 2020, para. 8)
>
> Also, in my experience, some patients requesting MAiD have had access to high-quality mental health care within the public system. Others have had no financial barriers and have had treatment in both the public and private sectors, over a span of decades, and yet still suffer intolerably. (Dembo, 2020, para. 6)

These experts depict vulnerability rhetoric as enabling paternalistic action that unjustly removes agency from an entire class of diverse people. They argue that because the problem of poor social determinants is not unique to those people with mental illness as a sole underlying condition, and MAiD is allowed for many physical illness conditions, these vulnerabilities cannot be used as justification for a blanket prohibition on MAiD. Otherwise, we risk denying the lived experiences of people with mental suffering who do have access to quality care and support, thus fixing vulnerability to people who might not see themselves as such. The last quote demonstrates how some experts explicitly rejected notions of inherent social vulnerability, instead maintaining that intolerable suffering, can, in some cases, be a direct product of mental illness alone.

Some proponents also argued that rather than reducing incentives to improve care and social supports, MMS could kickstart a scale-up of mental healthcare in Canada. For example, in a focal article for the *Journal of Medical Ethics*, two experts point to the drastic increase in funding supplied to palliative care since the legalization of MAiD in 2016 to demonstrate how MMS has the potential to act as an impetus to increase resources for mental healthcare across the country: "Canada's government has dramatically increased investments into palliative care provision. But increasing access to palliative care was never a precondition of (rather than an initiative concurrent with or following) the policy change" (Downie & Schüklenk, 2021, p. 667). Another psychiatrist maintained that MMS could help improve patients' access to care at a more immediate level:

> And if such a patient requests MAiD, they may then see a psychiatrist for the first time — a psychiatrist who takes their desperation seriously and carefully evaluates their eligibility — and they may gain access to better care as a result. In my clinical experience assessing requests such as these, this is what often happens. (Dembo, 2020, para. 6)

Here, Dembo suggests that MMS could act as a gateway to care for the most desperate psychiatric patients by providing them access to clinical expertise. It is possible, though certainly not guaranteed that allowing MAiD for mental illness could create opportunities to access mental health practitioners, thus reducing vulnerability. Contrary to the *protect the vulnerable* discourse, some experts also suggested that the exclusion of people with mental illness from MAiD, rather than the inclusion, could enhance patients' vulnerability.

Across the documents that I reviewed, some proponents of MMS believed that discourses of protection, perhaps unintentionally, contribute to the vulnerability of people with mental illness. For instance, in their position paper on MAiD, the *Ordre des Psychologues du Québec* claimed that patients' "vulnerability actually means not that they should be deprived of their rights, but that they should receive more support in exercising them" (2020, p. 11), which could be operationalized through the right-to-die. Likewise, one legal scholar argued that "those who do soundly decide that they want their lives to end are vulnerable in a different way: a ban on assisted dying makes them subject, against their will, to continue living a life they no longer want to live. In that sense their interest – and I would suggest their wellbeing – is threatened" (Tanner, 2017, para. 8). Others condemned the use of MAiD as a social platform, with one duo describing it as a form of "hostage-taking" (Downie & Schüklenk, 2021) whereby patients' suffering is used as leverage in debates over larger social problems. From this perspective, people with mental illness are used as props to push a narrative and are punished to decades of suffering as a consequence of larger social problems and inequities beyond their control.

Counter to prominent discourses of protection, some experts rejected the inherent vulnerability often ascribed to patients with mental illness and argued that it is the exclusion, not inclusion, of people with mental illness from MAiD that enhances patients' vulnerabilities and threatens their rights to proper care and support. As put by one bioethicist, people with mental illness are "being stigmatized in the name of protecting them" (Schüklenk, 2019, p. 220). Some experts further asserted that excluding people with mental illness from MAiD on the basis of vulnerability reaffirms negative stereotypes and reproduces longstanding conditions of oppression.

3.3 The Right to Non-Discrimination

It is undisputed that Canada should strive for equality for all its citizens and that all individuals in society should be treated impartially. This principle is codified in Section 15 of the Charter, which specifies that every individual in Canada – regardless of race, religion, national or ethnic origin, colour, sex, age or physical or mental disability – has the right to be treated with the same respect, dignity, and consideration (Government of Canada, 2022). I argue that this section carries particular importance for the debate around MMS considering the enduring stigmatization and widespread legitimation of discriminatory treatment and social exclusion of people with mental disorder(s) (see Busfield, 2014; Rose, 2018). Despite years of campaigning aimed at eliminating negative stereotypes and reducing prejudice toward people with mental illness, experts across my dataset on all sides of the debate agreed that a strong stigma remains ingrained in Canada's social fabric. However, there was serious disagreement about what constitutes equality for people with mental illness in the matter of assisted dying.

3.3.1 A Parity Perspective

In their systematic review of reasons for whether assisted dying should be permitted for psychiatric illnesses, Nicolini et al. (2020) found parity (or discrimination) based reasons to be dominant across the literature. Comparatively, my analysis revealed that parity arguments feature prominently in the expert debate about MMS in Canada. Parity arguments suggest that if MAiD is permitted for physical medical conditions, then it should also be permitted for mental illnesses. They rest on the assumption that there are no relevant differences between physical and mental conditions in this context; that mental illness is like any other medical condition and should therefore be treated in a similar manner. As described in the previous sections, experts endorsing MMS often believed that the concerns raised around decision-making capacity and social vulnerability are not unique to mental illness, rather, they are inherent to the general practice of assisted dying. Parity arguments similarly contend that it is discriminatory, and thus a violation of Section 15 rights, to deny people with mental illness access to MAiD based on their medical diagnosis, just as it would be to deny them any other government service.

Many proponents in my study argued that blanket prohibitions on MAiD perpetuate the unjust discrimination of people with mental illness. They drew comparisons between mental and physical conditions to argue that they are more or less the same, at least in the aspects relevant to MAiD eligibility – irremediable and intolerable suffering from a medical condition – and as such, excluding those suffering solely with mental illness from MAiD constitutes discrimination. For example, in an article for the *Toronto Star,* a group of experts asserted that “Only people with mental illness are singled out for exclusion. Why should mental illness be singled out if other unpredictable conditions are not?" (Gupta et al., 2021, para. 12), Likewise, one legal scholar argued that because there are other conditions which are currently eligible for MAiD whose trajectories are not well understood, we cannot discriminate against mental illness: "There are physical conditions that have similar uncertainties around prognosis and treatment effectiveness. Why is mental illness excluded based on these uncertainties when physical conditions with similar uncertainties are not? (Downie, 2020, para. 4). By drawing comparisons to physical illness conditions that are eligible for MAiD, I maintain that these experts framed the prohibition as conflicting with patients' right to equality.

Others were concerned about how the continued prohibition on MMS might further contribute to the stigmatization of people with mental illness. For instance, a legal expert raised concerns about what the prohibition of MMS says about mental illness as a medical condition:

> This amendment is stigmatizing. Relying on the notion that every mental illness is curable feeds the false belief that people with mental illness would get better if they just tried harder. Also, it doesn't take much imagination to see how the phrase "a mental illness is not considered to be an illness, disease or disability" might perpetuate the harmful idea that a mental illness is not a real illness, disease or disability. (Downie, 2020, para. 5)

Here, this expert describes the beliefs about mental illnesses that might simultaneously fuel and be fuelled by a blanket prohibition on MMS. Specifically, they maintain that coupled with the exclusion, the language used in MAiD law, especially remediability (or curability) and "illness, disease, or disability", reinforces the notion that mental illness is not a medical condition, or that it is somehow less of an illness than other medical conditions. Indeed, many proponents explicitly argued that mental illness is like any other medical condition, at least in terms of the basic requirements for MAiD: irremediable and intolerable suffering.

A prevailing argument within the parity perspective was surrounding the notion of suffering. Many proponents argued that mental illness should not be excluded from MAiD because mental suffering can be just as bad, or worse than physical suffering. For instance, one psychiatrist claimed that "anyone who would deny that the suffering caused by mental illness is sometimes just as horrid as the worst suffering caused by a physical ailment just hasn't been around long enough" (Bay, 2017, p. 4). Likewise, the current CEO of DWDC stated that "suffering caused by mental illness is no less 'real' than suffering caused by a physical illness, injury or disability. In many cases, symptoms of mental illness are indistinguishable from those caused by a nonpsychiatric medical condition" (Long, 2022, para. 10). These experts argued that, at least on the basis of suffering, it is discriminatory to deny MAiD to people with mental illness and to deny their right to assess the severity of their own suffering. As per another psychiatrist, "we do not question the subjective sense of suffering as often with physical illness; this is a product of stigma, in my view" (Dembo, 2020, para. 7). It is important to note that while many opponents did not deny that physical and mental suffering can be equally as devastating, they pointed to other fundamental differences between mental and physical conditions to argue that proceeding with MMS reflects something of an ableist agenda.

3.3.2 An Ableist Amendment

Various -isms have been used as missiles in the MMS debate, but the language of ableism was especially prominent in the documents I reviewed. Historically, ableism rhetoric has been used by disability rights activists who critiqued evolving assisted dying laws as reflecting and reinforcing ableist prejudices about the disabled "not having lives worth living and being 'better off dead' – prejudices responsible for the marginalization, stigmatization, and rights violations of the disabled" (Scoccia, 2020, p. 280). Across my dataset, ableism was cited as a dominant reason for prohibiting MMS. An *ableist amendment* posits that is it the inclusion, not the exclusion, of people with mental illness from MAiD that risks increasing stigmatization and constitutes potentially fatal discrimination.

In contrast to parity arguments, experts who framed MMS as an ableist policy argued that differential treatment of a group protects rather than violates peoples' rights to equality and non-discrimination. A primary argument supporting this perspective was that mental illness is fundamentally different in nature than other, MAiD-eligible, medical conditions and that it is discriminatory to ignore such critical differences. For example, expert opponents argued that unlike physical medical conditions, mental illness is characterized by transient despair (Coelho et al., 2022) contested or frequent misdiagnosis (Kaiser et al., 2021) misunderstood etiology and prognosis (Gaind, 2020), and is never the direct cause of death (Pullman, 2021). In fact, in the documents that I reviewed, a commonly debated aspect of mental illness was its (ir)remediably.

Across my dataset, some of the major mental health organizations argued that mental illness is never irremediable. In their 2021 position statement on MAiD, the CMHA declared that:

> Denying access to MAID for mental health reasons alone does not mean those with mental illness suffer less than people afflicted with critical physical ailments. What is different about mental illness specifically, is the likelihood that symptoms of the illness will resolve over time. (2021, para. 4)

In the quote above, rather than likening mental illness to physical illness, the CMHA distances it from physical ailments in terms of remediability and uses the distinction as justification for continuing to prohibit MMS. Likewise, the Canadian Association for Suicide Prevention (CASP) maintained that "mental illness can be grievous but it is never irremediable" (2021, para. 5) and CAMH "recognizes that people with mental illnesses can experience intolerable psychological suffering as a result of their illness, but there is always the hope of recovery" (2016, para. 1). Clearly, these organizations deny the possibility that mental illness could ever satisfy the irremediability criterion for MAiD. Given their position as major players in mental health services in Canada, their perceptions about the nature of mental illness have significant influence over the opinions of those who seek treatment from them as well as the broader Canadian public. However, it is important to balance these opinions against recent research suggesting that some DSM disorders can be the direct cause of death (e.g., anorexia nervosa, opioid use disorder) (see Gaudiani et al., 2022, for example). In addition to highlighting differences between the nature of mental and physical illness, experts against MMS noted differences in treatment to further exceptionalize mental illness.

Experts outlined the particularities of psychiatric treatment to further distinguish mental disorders from physical medical conditions and to justify the continued prohibition of MMS. For example, in an article for *Impact Ethics*, one psychiatrist called attention to the prolonged length of psychiatric treatment in comparison to some other medical interventions: "Standard psychiatric treatment protocols are not of short duration (months to years) and entails multiple treatment trials" (Maher, 2020c, para. 10). Another expert wrote that "mental health is the only specialty in which diagnoses are mainly based on the patient's description of symptoms…imagine for one moment if we used the same method with cancer" (Vrakas, 2019, para. 5). This expert then went on to argue that society would never accept this method of diagnosis nor the chronic underfunding and inaccessible treatment for physical illnesses in the way that it is tolerated for mental illnesses. This statement was just one of many that drew attention to the systematic stigma inherent in the organization of services and funding for mental health services in Canada.

According to much of the opposition, people do not die from mental illness, rather, they die from systemic stigma and marginalization that does not allow them to live. As per Gaind (2021a), if MMS were legalized, "oppression would force our most vulnerable to make an impossible, and unfair choice to 'die well' because society never gave them a chance to live well" (para. 11). The focus on dignified living reflects a shift in the national conversation about MAiD, whereby the focus has moved away from 'dying with dignity' to ensuring that all people can live dignified lives (Brassolotto et al., 2022). Several opponents raised concerns that allowing MAiD for mental illness would incite a fundamental shift in social expectations and societal norms around aid in dying. Take the words of one legal scholar, who argued that if MMS is implemented, assisted dying becomes a question of "whether we live at all rather than as a way of controlling our manner of dying" (Lemmens, 2020, para. 7). In fact, some experts compared MMS to past social horrors and atrocities such as eugenics in that they "started with reasonable ideologies that were then perverted and collectively supported" (Maher, 2016, p. 4). Indeed, Gaind (2022) believes that if Canada moves forward with MMS, we are "setting ourselves up for a future national apology" (para. 13). Across my dataset there was widespread concern among the opposition that legalizing assisted dying for mental illness will lead Canadian society to adopt an attitude that life with mental illness is not worth living.

Some experts claimed that the proposed changes to the law stigmatize people with mental illness by depicting them as disposable. In an opinion piece for the *National Post*, one legal expert stated that MMS "sends disturbing messages, teaching that human life is a depreciating asset with a "best before" date or that certain conditions are a "fate worse than death" (Bird, 2022, para. 5). In other words, they argued that if the government legalizes MAiD for mental illness, it sends the message that Canada is more prepared and willing to kill people with mental illness than to expand the welfare state. It is no surprise that the state's role in and motivation to pass MAiD legislation is being queried, especially at a time when the privatisation of public health services is being regularly debated.

Through this discourse, experts constructed MMS as an ableist and life-devaluing policy. In many ways, the oppositions' arguments mirror longstanding concerns about physical disabilities and assisted dying (see Scoccia, 2020 for example). Experts argued that offering MAiD to people with mental illness does not constitute equality, because it is fundamentally different from physical medical conditions and thus should not be treated in an identical manner. As one psychiatrist stated in an article for the *Globe and Mail* "equity does not mean everything is the same. Equity involves impartial and fair evaluation of situations" (Gaind, 2016, para. 14). Some opponents suggested that changing MAiD criteria would encourage undignified living conditions by offering an easier remedy for suffering in the absence of adequate social and medical supports. In other words, Canada would be providing more equitable access to MAiD, or death, as opposed to providing equitable access to life. *An ableist amendment* frames the inclusion of mental illness into

MAiD as discrimination and thus, I contend, as violating people's section 15 rights to equality and non-discrimination.

3.4 Toward a Less Biomedicalised Model of Mental Suffering?

Across my dataset, experts used rights-based discourses to underscore the state's role in upholding the rights of its citizens and alleviating mental suffering. Embedded within these discourses, however, were noticeable differences in experts' conceptualizations of mental illness and suffering. Specifically, my analysis revealed tension around understandings of mental illness and the roots of mental suffering, which in turn impacted experts' opinion about the appropriateness of allowing MAiD for mental illness. Indeed, in a reflection paper for the *Journal of Ethics in Mental Health*, one psychiatrist stated that before attempting to broach the subject of assisted dying for mental illness, we must "come to grips with the question of whether a good part of the suffering is rooted in societal attitudes and responses to those with mental health challenges rather than something wholly within the individual" (Bay, 2017, p. 2). Clearly, the MMS debate forces us to consider what kind of medical condition mental illness is, if one at all.

As described in the literature review section of this thesis, Canadian psychiatry is a medicalised field (Conrad & Schneider, 1992) and defines more behaviours, thoughts, and emotions as mental illness than ever before (Horwitz, 2002). Although they do not address mental suffering specifically, in their analysis of *Carter v. Canada*, Karsoho et al. (2016) claim that proponents of assisted dying make use of the medicalisation framework for emancipatory ends. Likewise, I maintain that a medicalised perspective of mental suffering is often taken up by proponents of MMS as it frames MAiD as a straightforward solution to an irremediable medical problem.

By arguing that "mental illness is like any other illness", some experts in my dataset promoted the dominant biomedical approach to mental suffering which frames the problem as being internal to the person and resulting from biochemical processes and therefore necessitating biomedical treatment. From this perspective, mental suffering should not be exceptionalized or made exempt from medical treatment interventions that are available to people with other conditions because mental illness is no different than other MAiD-eligible conditions. As succinctly put by a prominent legal scholar, "there is no justification for treating similar cases differently" (Downie, 2020, para 6). However, the arguments deployed against MMS often rejected the notion that "mental illness is like any other illness" and challenged the dominant conceptualization and treatment of mental suffering as a medical concept.

Sociologist Smith (2011) argues that "when psychiatry (especially biological psychiatry) is seen as the legitimate model for conceptualizing mental suffering, the social perspective is precluded" (p. 361). A recurring concern across my dataset was that if MAiD is considered a legitimate option to treat mental suffering, we lose the potential to understand suffering as something much greater than a medical problem, as not only an irremediable condition located within the individual, but as dependent on the relation between the individual and the external environment. My analysis found that the rights-based discourses advanced by experts often depicted the grievous suffering experienced in mental illness not as directly illness-related, but rather as stemming from social factors such as social isolation, poverty, inadequate housing and healthcare, and stigma.

In their recent writing about psychiatric euthanasia, Maung (2022) argues that an externalist approach to mental illness, that is, one that encompasses the processes between the individual and the external environment, presents an ethical challenge to assisted dying. Likewise, I argue that through a legal rights frame, opponents of MMS encourage a less biological approach to mental suffering that takes socio-structural factors into greater consideration than the traditional biomedical framework. A primary concern among the opposition in my dataset was that under a dominant, biomedical approach to mental illness, people who could have recovered by means of improved social supports and access to care, will instead be put to death prematurely (see Faruqui, 2022 for example). Hence, they advocate for non-medical (social) alternatives to MAiD based on the fear that people who might seek MAiD for cases of mental illness are seeking escape from social disenfranchisements, not from inevitable medical suffering.

I argue that opponents of MMS not only challenge assisted dying, but also challenge the larger framework of medicalisation within which mental suffering is commonly experienced and treated in Canadian society. A rejection of medicalisation is made explicit in a statement by Inclusion Canada, where they write that the "trend towards the medicalisation of suffering, to be treated through termination of life, skews entirely the role of the medical profession and sets a very dangerous course for society" (2017, para. 4). While experts did not appear to reject certain medicalised aspects of mental illness, such as the authority of psychiatry to treat patients with mental illness, legal rights-based arguments nevertheless seemed to re-open the conversation around a less medicalised, or partially demedicalised understanding of mental suffering.

According to Braslow and Messac (2018), demedicalisation can be useful when questioning our understanding of and care for diseases that blur boundaries between the social and the medical. Demedicalisation is the "transformation of problems formerly understood to be medical in nature into problems understood to be nonmedical" (Braslow & Messac, 2018, p. 1887) or "stripping away medicine as the dominant frame of reference to reveal the "true" nature of the phenomenon" (Ost, 2010, p. 500). Thus, it could certainly be argued that opponents of MMS advocate for at least a partially demedicalised model of mental suffering that privileges social interventions and understands mental illness primarily as non-medical (social) suffering. By emphasizing the social dimensions of suffering, opponents engage in a (re)conceptualization of mental illness in terms of the social, political, and economic climate within which it occurs. Moreover, experts' articulation of mental suffering constitutes a broader discourse through which the only acceptable response to mental suffering becomes larger socio-structural change.

3.5 Chapter Summary

In the documents that I reviewed, disagreement over the way in which MMS impacts patients' Charter rights underscored expert dissensus in conceptualizations of mental illness and suffering. The polarizing arguments at the heart of legal rights-based discourses – about autonomy, vulnerability, and equality – call into question the designation of mental illness as a biomedical category and medical treatment as the prevailing remedy for mental suffering. Some experts tended to invoke more biomedical, internalist explanations for mental illness. Depicting mental illness as sharing more similarities than differences with other medical conditions, they argued that it should be amenable to the same medical treatment options to protect patients' rights to autonomy and equality. Others relied on a more externalist view of mental illness, arguing that there are critical differences between mental and physical illness conditions and that mental suffering should be exceptionalized in the name of protection and anti-ableism. They suggested that a purely biological approach to mental illness ignores the crucial relationship between mental suffering and social context to argue against MMS. In place of assisted dying, they advocated for increased access to social supports and care. Against a backdrop of a decades-long effort to define and medicalise mental suffering, my study found that tensions around conceptualizations of mental illness and medicalisation underpinned expert MAiD talk. Expert opponents were concerned about the overmedicalization of mental health, of turning everyday social issues into medical problems, yet nonetheless advocated for improved access to medical mental healthcare. Expert proponents tended to promote a more biomedical view of mental illness and used its status as a medical condition to argue for the implementation of MMS.

The rights-based discourses that emerged from expert debates about MMS highlight the challenges inherent in navigating issues that occur within medico-legal borderlands. Clearly, expert debates about the nature of mental illness and the appropriate response to mental suffering do not provide neat policy solutions. Maturo (2012) argues that it is oftentimes easier for political institutions and law to embrace a biological definition of illness because if one considers illness as an external risk with social causes, the responsibility to avoid it is shifted from the individual to society and social policy. From a policy perspective, treating symptoms with medication – or MAiD – is much more feasible than reorganizing the social structure (Navarro & Shi, 2001). Irrespective of

MAiD, the debate demonstrates the need for serious political debate about Canada's responsibility to address the social inequities experienced by people with mental illness.

Months after the completion of my data collection, these discourses persist in Canadian news media with more frequency and ferocity than ever before. Several cases that have received national and international attention report on individuals who requested and/or received MAiD due to issues such as inadequate income, housing, healthcare, and other social supports (see Favaro, 2022; Moran, 2020; Mulligan & Bond, 2022; Muzaffar, 2022). Although it is unlikely that rights-based arguments will abate any time soon, at some point in the debate, a new framework was introduced through which MAiD was presented by advocates of the practice as a viable option for people experiencing unbearable mental suffering. In addition to being "cast as a battle between respect for autonomy and protection for the vulnerable situated in the courtrooms of the nation" (Downie, 2022, p. 328), MMS was recast as a battle over the appropriate role of psychiatry and what constitutes quality mental healthcare in Canada, situated in the patient-psychiatrist relationship (Downie, 2022).

CHAPTER 4: CLINICAL ETHICS-BASED DISCOURSES

Whereas a legal rights-based approach to MMS contemplates what rights should be granted to a person in situations of intolerable mental suffering, a clinical ethics frame asks what constitutes appropriate care in such situations (Gupta, 2016a). In the documents that I reviewed, clinical ethics-based discourses raised questions regarding the sanctions and expectations placed on the medical community, especially psychiatrists. Experts queried how MMS would interact with ethical medical standards and subsequently impact patient care. Within these discourses, the question of whether people with mental illness should be included or excluded from MAiD was replaced by asking whether we have abided by existing clinical norms for such patients who request to die. As per one Canadian psychiatrist, by framing MAiD as a "response to exceptional clinical circumstances the norms of ethical practice can guide us" (Gupta, 2016a, p. 2). My analysis of the discourses around clinical responsibility revealed controversy among experts regarding the compatibility of assisted dying and psychiatry.

In an analysis of the debate about MAiD for mental illness, why focus more broadly on psychiatry and not solely on mental illness itself? Some social scientists have argued that the two are inseparable; as Rose (2018) states: "the idea of madness, mania, melancholy, and more as illnesses is, in large part, a function of the history and reality of psychiatry" (p. 1). As the speciality responsible for the management of many behavioural, contested, and misunderstood conditions (Rosenberg, 2006), psychiatry shapes both how we know, talk about, and intervene upon mental illness (Rose, 2018). Moreover, the discipline defines and delimits the boundaries of who is or is not suitable for treatment (Rose, 2018), which in this case is assisted death. Given the aim of this thesis to explore the arguments for and against MMS and to understand experts' conceptualisations of mental illness through MAiD talk, it is critical to explore not only how mental illness itself is discussed – as was addressed in the previous chapter – but also how experts negotiate the goals of mental healthcare and the psychiatrist's role in the treatment of people with mental illness.

In this chapter, I demonstrate how experts constructed MAiD as either consistent with or entirely incompatible with psychiatric care and consider what clinical ethics-based discourses reveal about perceptions of mental healthcare in Canada. Experts' depictions of MMS as either advancing or undermining psychiatry relied on assumptions about what constitutes quality care for patients with mental illness. There was dissensus over whether MAiD should be classified as an exceptional medical intervention or, as several opponents argued, state-facilitated suicide. Experts also disagreed about the implications of MMS for the patient-psychiatrist relationship and often supported their arguments by creating a distinction between psychiatry and other branches of medicine.

Situated within the patient-psychiatrist relationship and the broader clinical context of mental healthcare in Canada, I argue that experts' position on MMS depends, at least in part, on their understanding of psychiatry's role and approach to the care of patients with mental illness. Experts' standpoints were intimately linked to their perceptions of assisted dying – as a medical intervention or suicide – and approaches to care – patient-centered and evidence-based. I further contend that in a similar manner to how legal rights-based discourses revealed a contentiousness about the classification of mental illness, clinical ethics-based discourses reveal an underlying critique of psychiatry that reflects the enduring precarity of the discipline.

4.1 The Role of Psychiatry

Experts repeatedly raised psychiatry's role in the management of mental illness to support both the allowance and prohibition of MMS. Depending on what they considered to be psychiatry's primary role, experts argued that legalizing MAiD for mental illness would either support or undermine psychiatry's commitment to ethical professional standards of care. Disagreement about the compatibility between psychiatry and assisted dying often relied on differences in opinion about the classification of MAiD. Some experts equated MAiD with suicide and argued that it would conflict with one of psychiatry's primary duties: suicide prevention. Others likened it to any other medical intervention and portrayed MMS as an essential part of quality medical care aimed at alleviating suffering. In other words, experts emphasized psychiatry's role in either suicide prevention or alleviating mental suffering to justify the prohibition or legalization of MAiD for mental illness. Moreover, the language used to describe the practice, that is, MAiD or suicide, often directly correlated with support or opposition to MMS.

4.1.1 Preventing Suicide

Throughout the history of assisted dying in Canada, a major source of tension has been its reflexive association with the act of suicide (Downie, 2022). Exhaustive discussions about the similarities and/or differences between MAiD and suicide can be found in news reports and magazine articles (Downie et al., 2021; Favaro, 2022), academic articles (Friesen, 2020; Hannig, 2019; Norwood, 2018), senate testimonials, and other public forums. Typically, those in favor of assisted dying invoke categorical distinctions between the two acts in an attempt to distance MAiD from persistent social taboos and moral outrage that continue to surround suicide (Hannig, 2019). Indeed, in Canada, the term MAiD was intentionally chosen to avoid conflation between the two practices (DWDC, 2022). Nevertheless, many experts across my dataset – generally those who oppose MMS – equated MMS with suicide.

Some experts made a more implicit connection between the two practices by citing Canadian suicide rates (Sinyor & Schaffer, 2020; Vrakas, 2020), describing the phenomenon of suicide contagion (CASP, 2020; Nicholas et al., 2021), using the term "assisted suicide" (Bird, 2022; Steiner, 2017), or using the two terms – MAiD and suicide – interchangeably (Maher, 2020a). For example, in response to the CPA's statement on MAiD for mental illness, the president of the Ontario Association for ACT & FACT wrote: "your support for Bill C-7 is suicide facilitation" (Maher, 2021, para. 2). Others similarly described the practice as "socially abetted suicide" (Gaind, 2021b) and "medicalised suicide" (Pullman, 2021). Some statements created a more explicit association between the two acts:

> Holding a gun to your head, sticking a needle in your arm, or holding a poison pill and glass of water in my hands for you to take, are all morally equivalent actions. I intend to have you die. I am helping you complete suicide. (Maher, 2020a, p. 3)
>
> This is, in ethics and relationships, what MAiD is: a request of a physician to participate in suicide. (Simpson, 2017, p. 82)

These quotes show that these experts denounce the use of MAiD terminology. They understand MMS as another means of suicide and maintain that alternative terms, like MAiD, are only euphemistic attempts to legitimize suicide by distancing it from its value-laden meaning (Maher, 2020b). Although the morality of suicide itself was broached occasionally, experts focused more on the morality and practicality of involving psychiatry in assisted dying, or as put by two expert opponents, “state-sanctioned suicide” (Faruqui, 2022; Maher, 2020b).

Most of the opposition did not frame suicide as inherently wrong and even portrayed it as a comprehensible answer to the problems and torment that often accompanies living with severe and chronic mental illness, though they hoped not the best alternative. For instance, when considering the ethics of MMS in a perspective piece for the *Canadian Journal of Psychiatry*, one psychiatrist stated: “we must not condemn a person for feeling suicidal or for taking his or her own life. But neither do we want to encourage or facilitate suicide, and we may condemn anyone who does so” (Simpson, 2017, p. 83). Here, it is evident that not all expert opponents take issue with suicide itself. Rather, they condemn the involvement of others, especially psychiatrists, in an individual’s self-directed death. A dominant concern among opponents was how the legalization of MMS would impact psychiatry as a profession.

Throughout the documents that I reviewed, opponents of MMS consistently constructed the practice as running counter to the fiduciary obligations of psychiatrists, namely, suicide prevention efforts. If the main goal of psychiatry is to prevent suicide and preserve life, then MMS understandably presents a challenge to the discipline for those who view psychiatrists administering MAiD as a “sanitized version of a gun” (Maher, 2017, p. 2). Some experts were adamant that a psychiatrists’ duties should never involve death, lest they abandon their ethical obligations and professional standards of care:

> A neurosurgeon removes brain tumors with aplomb. I help people make meaning of their suffering and find hope and purpose no matter what their life circumstances. Both specialists will fail from time to time, but our job and goal are clear. Just as the Pope should not perform abortions, and the Dalai Lama should not take up arms, a psychiatrist should not counsel or abet suicide, for in

> doing so I have misunderstood and betrayed my vocation and profession. (Maher, 2017, p. 4)

Here, Maher establishes psychiatry as a specialized discipline whose primary duty is to prevent suicide. Likewise, Simpson (2017) argued that "the role of psychiatrists in the mental health system is to assist people in recovery" (p. 82) and Vrakas (2019) declared that "those of us in the mental health field believe in recovery, which means working with patients in an empowerment perspective as they reconstruct themselves…[and] their dignity while living with their mental illness" (para. 10) Statements like these not only portray MMS as fundamentally incompatible with psychiatry, but also shun mental health practitioners who do support MAiD for mental illness.

Some of the more extreme opponents argued that MMS should remain illegal for more pragmatic reasons. Notably, some authors maintained that since suicide is legal, patients with mental illness do not need access to MAiD because they can terminate their lives at their own volition. As one psychiatrist put it: "people living with mental illness can swallow their own suicide pills" (Maher, 2017, p. 2) Experts taking this "let them kill themselves" (Dembo et al., 2018) approach also often sternly expressed that they did not consider MAiD to be medical in nature. For example, one of the major suicide prevention organizations wrote that "as mental health advocates, CASP wants to ensure those suffering from mental illness are treated by medical means and not through assisted dying" (CASP, 2021a, para. 5) According to CASP, assisted dying clearly falls outside the scope of medicine; a sentiment echoed by many of those against the legalization of MMS. From this perspective, if MAiD is not a medical act, then psychiatry, a medical discipline, need not be involved.

Ultimately, experts speaking from this discourse maintained that psychiatry and MMS occupy fundamentally incompatible moral and pragmatic positions. They argued that allowing psychiatrists to act as agents in their patients' deaths would contaminate the discipline, assuming that psychiatry's primary role is to intervene to prevent death. Such are the laws that have long required mental health practitioners to involuntarily admit patients to treatment centers (Kolar et al., 2022). Experts who equated MAiD with suicide framed MMS as violating the ethical standards of psychiatric care and breaching psychiatry's established moral posture. Undoubtedly, the decision to legalize MAiD has important implications for psychiatric practice. However, other experts oppositely maintained that psychiatry, and its patients, could benefit from the implementation of this practice as a form of mental healthcare.

4.1.2 Alleviating Suffering

Anthropologists who have intimately studied assisted dying through immersion into the experience of patients, families, and doctors found that aid in dying was often perceived as a way of enacting care for others (Buchbinder, 2021; Gandsman, 2018; Stavrianakis, 2020). Likewise, in the documents I reviewed, many expert proponents framed MMS as compassionate care for those suffering from severe mental illness. They argued that Canadians with mental illness should not be faced with the cruel choice between intolerable suffering and an often lonely, violent, or dangerous self-inflicted death. These experts sought to distance MAiD from suicide by painting MMS as a good, or at least a better death than suicide and ultimately as an important part of quality, compassionate and progressive mental healthcare (see Munro, 2017; Chandler & Hatcher, 2016 for example).

In contrast to those experts who equated MAiD with suicide and depicted it as contradictory to the fundamental tenets of psychiatry, others – typically proponents – framed MMS as essential medical care aimed at alleviating suffering:

> It might be more helpful for [mental health professionals who deal with requests for MAiD] to look at things from a different angle and see MAiD not as an abandonment or a failure, but rather as yet another form of care that serves their humanitarian values. (*Ordre des Psychologues du Québec*, 2021, p. 19)
>
> There are times in the course of clinical care of a medical problem or set of problems when there is nothing left to offer to alleviate a patient's suffering from that very problem. This is as true in psychiatry as it is in any other area of medical practice. Wanting to die in such circumstances may have many facets depending on the patient: social, existential, and even financial. But such a desire also reflects something about the facts of a medical problem. Doctors may not have a treatment to offer but why would they suddenly stop playing a part in helping patients to address their suffering? And if they use medical knowledge and skills to do the only thing left to relieve suffering in a safe manner, why would this not constitute a medical act? (Gupta, 2016a, p. 1)

These excerpts reveal an alternate understanding of MAiD as an essential part of good and complete medical care in contemporary Canadian society. By depicting mental illness as a medical problem and MAiD as a medical intervention, these experts liken psychiatry to other areas of medicine and questions why a doctor would stop providing care to their patient, instead of helping to address their suffering through medical means. Rather than undermining the moral duty and goals of psychiatry, experts who prioritized psychiatrists' role in alleviating mental suffering often described MMS as a logical progression in the advancement of psychiatric care.

Nevertheless, proponents were understanding of the widespread ambivalence toward involving psychiatry in assisted dying. They recognized that MMS might shake certain values that have long guided professional practice. In fact, in response to an editorial written by a staunch MAiD opponent, another psychiatrist agreed that "given their traditional role in the care of suicidal persons, [they are] right to highlight the concerns shared by many in the field" (Gupta, 2016a, p. 1), but then went on to say that the "norms of good clinical practice can guide us through the issues [they] raise" (Gupta, 2016a, p.1). Gupta's use of the words "traditional" and "good clinical practice" perhaps implies that psychiatry's main role has shifted over time, suggesting a reconceptualization of psychiatry and a reframing of MMS as medical care.

Given that psychiatrists often have long-standing relationships with patients and their families, some experts argued that refusing to participate in MAiD is equivalent to abandoning a patient with mental illness at a time when they most need care and support. As per one mental health specialist, "even with the best medical care, people die as a result of illness" (Baylis, 2020, para. 3). Indeed, unlike the rest of Canada where patients can choose between self-administered (assisted suicide) or physician-administered MAiD, in Quebec, MAiD must be administered by a doctor (Government du Québec, 2022). That MAiD must be administered by a medical professional suggests that aid in dying is meant to be a final act between doctor and patient. Not only did expert proponents construct MAiD as medical care by emphasizing psychiatry's role in alleviating suffering, but they also highlighted, as per Gupta (2016a), "the importance of accompaniment, rather than withdrawal, in the face of therapeutic failure" (p. 1).

4.2 The Therapeutic Relationship

The therapeutic relationship was another recurring object across my dataset. Experts disagreed about the best approach to care and how this relationship – between a psychiatrist and their patient- would be impacted by the proposed changes to MAiD eligibility criteria. On one hand, those in favor of MMS generally expressed that legalizing the practice could have a positive impact on the therapeutic relationship. They argued that it would validate patients' suffering, foster a safe space for open discussions about the desire to die, and importantly, promote patient-centered care. On the other hand, opponents often depicted the practice as having negative implications for the relationship and raised concerns about moving legislation forward given a lack of evidence about MMS. They problematized the power differential inherent to the relationship and were deeply skeptical about how a MAiD-supporting psychiatrist might impact patients' chances for recovery by influencing levels of hope. Although not all experts saw these two approaches to care – patient-centered and evidence-based – as mutually exclusive or referred to them explicitly, all were concerned about causing harm to the therapeutic relationship, and in turn, to the patient.

4.2.1 Patient-Centered Care

Until recently in biomedicine, physicians' commitment to beneficence and non-maleficence meant that decisions often lay in physicians' hands (Dembo et al., 2018). However, social scientists have pointed out that an overly strict adherence to these principles can equally cause harm to the patient by neglecting to consider the patient's value system (Revell-Dennett, 2018). This thinking is reflected in contemporary medicine’s commitment to patient-centered care, which encourages collaboration between physicians and their patients to ensure that patients’ values and wishes are prioritized throughout the therapeutic process, rather than excluding them from medical decision-making (Fang & Tanaka, 2022).

Given the history of paternalism outlined earlier in this thesis and considering ongoing patient empowerment movements, it has been argued that a patient-centered approach must be prioritized in psychiatry (Shields & Beidas, 2022). Indeed, psychiatry does not always “conform to the voluntarism that is held to be paradigmatic of professional medical practice” (Busfield, 2014, p. 29). Since the 1970s, partly due to the influence of Nigerian psychiatrists (see Heaton, 2013), the voice of the psychiatric patient has begun to achieve more legitimacy worldwide (Rose, 2018). Several experts across my dataset framed MMS as the epitome of patient-centered care for people with mental illness. At the same time, they framed the blanket exclusion of mental illness from MAiD as overtly physician-centric.

Unique to Canada’s MAiD framework is the requirement that to request and/or qualify for an assisted death, a person must endure suffering that is unbearable to them and that cannot be relieved under conditions that they consider acceptable (Government of Canada, 2023). Key to this criterion is that the patient, not the physician, determines the acceptability of treatment. MAiD law recognizes that medicine cannot help everyone to the point where they find their quality of life to be acceptable when they assess it themselves; it acknowledges the subjectivity of suffering and places the patient at the centre of care (Dembo, 2020). Thus, some expert proponents argued that allowing MMS would put the patient at the forefront by allowing competent adults the opportunity to decide how they want to manage their own mental suffering within a medical framework.

Consequently, many of these experts also argued that continuing to prohibit access to MAiD for people with mental illness represents a physician-centric approach to psychiatric care. They condemned those who shifted the focus of the debate away from the patient toward the psychiatrist:

> The other issue, in my mind at least, that does not belong in today's discussion is the impact that assisted dying may have on the sensibilities of physicians…We need to remind ourselves that the health care system in general, and the assisted dying debate, is not about the professionals. Docs and nurses and even has been lawyers like me are not at the centre of the universe. The health system and the delivery of health care is not about us; it's about the people that we serve. (Bay, 2017, p. 3)

Here, Bay articulates the view that the debate over MAiD for mental illness should not be about physicians. Later in the same article, Bay (2017) adds that "we have fought too long and too hard to put patients at the centre of the health system to give any of that ground back" (p. 3). Other experts emphasized that patients should not pay the price for physicians' discomfort and thus should not be reasonably expected to continue to live lives that they, themselves, do not consider worth living. This does not mean, however, that physicians cannot opt out as conscientious objectors, so long as they properly refer patients who seek assisted dying[12] (Government of Canada, 2023). Nevertheless, some experts criticized psychiatry for choosing to opt out of MAiD as part of a legitimizing strategy.

For decades, psychiatry has suffered a crisis of legitimacy in North America and Europe (Fabrega, 1993; Morgan, 2015). In discussions about the diagnostic process and

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[12] MAiD law in some regions of Canada requires that when physicians are unwilling to provide assisted dying for reasons of conscience or religion, an effective referral to another healthcare provider must be provided to the patient (Government of Canada, 2023).

treatment practices, the legitimacy crisis is evident in the expert debate about MMS. When discussing why some psychiatrists might be against allowing MAiD for mental illness, one mental health practitioner stated that:

> Perhaps practitioners feel a need to be viewed as having the ability to relieve the suffering of their patients. In psychoanalytical terms, this need becomes a confirming narcissistic reflection in the service of the ego. The patient's suffering gives rise to the caregiver's identity. Death does not provide this service to the ego, but nor should the unremitting and unbearable suffering of a patient. (Baylis, 2020, para. 6).

This excerpt bluntly showcases why one expert believes psychiatrists might be against the implementation of MMS. It insinuates that psychiatrists may benefit from the prolonged suffering of patients. It also rejects the argument that mental illness can always be cured and negatively portrays the discipline as putting provider needs ahead of its patients'. Moreover, such an inability to recognize or accept the limitations of medical science is depicted as being unique to psychiatry. In this way, I maintain that some experts see the MAiD debate and specifically psychiatry's resistance to MMS as highlighting a persistent need in psychiatry to defend its position as a healing entity and justify its place in medicine.

Rather than denying patients with mental illness access to MAiD, many proponents argued that allowing MMS would help bring psychiatry into alignment with other branches of medicine, by accepting death as a possible outcome and putting the patient at the centre of care. They maintained that psychiatry must accept its limitations, in the same way that other branches of medicine do, and permit MAiD in those rare cases where patients may not recover. Obviously, not all experts agree that MMS constitutes a progressive form of patient-centered medical care. Indeed, the CMHA (2021), among others across my dataset, maintained that what truly puts a patient at the centre is recovery-oriented and evidence-based care.

4.2.2 Evidence-Based Care

Across my dataset, several experts raised the concern that MMS does not reflect a scientific evidence-based practice. Such evidence-based concerns were supported by claims that there is limited knowledge about the etiology and prognosis of mental illness as well as minimal – yet problematic - data detailing the practice of psychiatric euthanasia in the Netherlands and Belgium. In fact, some experts argued that the only reliable evidence that currently exists is that access to quality treatment and support works to alleviate suffering and promote recovery for patients with mental illness (Kim & Lemmens, 2016; Lemmens, 2020; Maher, 2020a; Vrakas, 2016). Consequently, my dataset was riddled with repeated demands for more evidence prior to the implementation of MMS.

Many experts against MMS cited concerns that proponents of MMS were pushing ideology rather than evidence. For example, in a piece for the *Hamilton Spectator*, two psychiatrists argued against MAiD for mental illness on the grounds that public health policy "should be based on available evidence and standards, not arbitrarily on individual value judgments of assessors" (Gaind & Tang, 2021, para. 8). Likewise, in an op-ed for the *Globe and Mail*, another psychiatrist duo described the decision to expand MAiD criteria as a "Kafkaesque scenario where handwaving arguments based on missing or unacceptably poor-quality data were presented to courts and legislators as scientific facts" (Sinyor & Zaretsky, 2021, para. 5). These quotes suggest that there is not enough quality evidence to move forward responsibly and ethically with MMS.

Sociologist Busfield (2014) has argued that psychiatrists' power, authority, and prestige lies in their scientific knowledge and that psychiatry is expected to be based on science rather than ideology. In a written response to a *Policy Options* article accusing the

Assemblée Nationale du Québec of reporting misleading statements and logical inconsistencies in their recommendation on MMS, a group of experts similarly wrote that Canadians never envisioned that MAiD would be a value-based decision, "instead, they trusted there would be some science and evidence behind it" (Coelho et al., 2022, para. 10). They worried that the option of assisted dying would undermine the foundation of trust upon which the therapeutic relationship is built. Indeed, another psychiatrist lamented that "some of [their] psychiatrist colleagues are ignoring evidence and reassuring Canadians that expansion is "enlightened and 'safe'" (Gaind, 2021a, para. 13). This statement frames the practice as dangerous while simultaneously creating negative perceptions of MAiD-supporting psychiatrists as deceptive and willfully ignorant or as intentionally withholding evidence that refutes MMS. In addition to notions of trust in psychiatry, another major concern among opponents revolved around the role of hope in the therapeutic process.

In the proclaimed absence of evidence around the prognosis and treatment of mental illness, some opponents made the claim that what evidence does exist shows that remaining hopeful is a basic therapeutic tool for the psychiatrist and a basic condition of recovery for the patient (Van Veen et al., 2020). Opponents argued that presenting MAiD as a viable option for those experiencing mental suffering might reinforce loss of hope and demoralization, thus endorsing death:

> Clinicians must at all times remain engaged and try to help as best they can. Giving up on hope may be dangerous for mental health services. (Simpson, 2017, p. 82)
>
> Were a medical professional to agree to MAiD for a patient solely suffering from psychiatric illness, this could contribute to the patient's loss of hope. Psychiatric patients often look to their psychiatrist or medical practitioner for answers, and if death, rather than recovery, is considered a medically-viable option, the resulting lack of hope may cost them their lives. (CMHA, 2017b, para. 6)

> Would it not make someone with depression even further depressed if their physician agreed that they should die? Would euthanasia generate its own demand?" (Lau & Fernandez, 2016, para. 9)

These quotes demonstrate that some experts working in the mental health system are concerned about the power dynamic between doctor and patient in the context of MMS. They support the CMHA's (2017a) belief that if the practitioner – the patient's advisor and authority figure – agrees with their wish to die because of mental illness, it serves as an "indirect admission that the patient will never recover and that they cannot recover from their mental health condition" (p. 7). In other words, by supporting and/or participating in MMS, some opponents argued that psychiatrists might increase peoples' sense of hopelessness and influence their patients towards assisted death, making them complicit in patients' decisions to end their lives.

Considering a lack of evidence to guide decisions about MMS, some experts were especially concerned about the significant discretionary power that would be afforded to psychiatrists in the absence of judiciary overview. Specifically, there were concerns that in the face of therapeutic failure, the psychiatrist, feeling powerless, would offer assisted dying to feel helpful (see Gaind, 2020). Expert opponents drew upon psychiatry's involvement in historically inhumane practices to construct an image of psychiatrists as unscrupulous physicians who would enthusiastically provide MAiD to their patients:

> There will always be a minority of psychiatrists willing to kill their patients. They get burned out, from their clinical vantage point they believe nothing more can be done, or they are resigned to the lack of funding for adequate treatment. (Maher, 2020a, p. 3)

> And are we sufficiently confident that we have the ability to do this, cognizant of the involvement of psychiatry in the eugenics movements of the past? (Simpson, 2017, p. 82)

Here, experts question psychiatry's capacity to be involved in assisted dying, given its marginalized status within medicine and its ethically troubled history. They argue that MAiD will present an "easy" option to a discipline that is plagued by elusive cures, a lack of funding, and harsh criticism. The arguments driving this discourse reflect a continuing effort to distance psychiatry from the rest of medicine and highlight longstanding negative perceptions and distrust of the discipline.

4.3 A Critique of Psychiatry

In the documents I reviewed, clinical ethics-based discourses highlighted disagreement among experts regarding psychiatry's compatibility with assisted dying. Although the focus and context of these discourses – the role of psychiatry and the therapeutic relationship – was assisted dying, I argue that they also reflected a larger contentiousness around contemporary mental healthcare and psychiatry. Psychiatry is intensely political and is no stranger to external scrutiny or internal division (Helén, 2007; Kirmayer et al., 2015; Rose, 2018). However, controversies about the discipline seem to have been reinvigorated in the wake of discussions around MAiD for mental illness. Indeed, in an article for the *National Post*, one physician stated that the debate has thrown the medical community into "civil war" (Faruqui, 2022). I argue that a critique of psychiatry underlying clinical ethics-based discourses reinforces its marginal status in the hierarchy of medicine.

Across my dataset, several experts who supported the legalization of MMS maintained that although there have been major improvements in psychiatric care over the past few decades, treatment futility persists:

> We accept the fact that modern medicine cannot alleviate all suffering in the physical realm; I worry when psychiatrists cannot accept this fact in the psychiatric realm…. In a perfect world, we would cure all suffering; but in this imperfect world, we should be humble enough to acknowledge that we cannot." (Dembo, 2020, para. 12)

Here, this psychiatrist distinguishes physical healthcare from psychiatry and criticizes the latter for upholding a belief in an ever-present remedy for mental suffering. Other experts similarly argued that the limits of medicine (i.e., death) exist equally in psychiatry as they do in any other medical discipline and that psychiatry's refusal to acknowledge death as a possible treatment outcome reflects something of its heightened ego or immaturity compared to other branches of healthcare (see Baylis, 2017; Von Fuchs, 2017). They criticized the discipline as taking a physician-centered approach to care in an effort to prove themselves as legitimate healers in the medical world. Moreover, they portrayed the blanket exclusion of mental illness from MAiD as inappropriately serving the interests of psychiatry, rather than those of their patients. In the words of Baylis (2020) such a "hubris of overconfidence in the effectiveness of treatment risks being a cornerstone of treatment futility, which aggrandizes a field at the expense of others' suffering" (para. 2). These critics held that rather than prohibiting MMS, legalization would constitute a progressive and legitimizing step forward for psychiatry, as it would bring the discipline into greater ideological alignment with the rest of medicine.

Although opponents of MMS did not agree that legalizing the practice would advance psychiatry, they nevertheless used language which similarly implied psychiatry's precarious position in the hierarchy of medicine. Twenty years ago, anthropologist Fabrega (1993) argued that as a medical discipline, psychiatry was compromised by not having its ontological roots well-articulated and validated. In the expert MAiD debate, similar problems of validity and legitimacy were reflected by expert opponents who cited psychiatry's limited understanding of mental illness and lack of scientific evidence as reason to limit the disciplines involvement in medical practices like MAiD. For example, one psychiatrist stated in an opinion article for the *Montreal Gazette* that "psychiatric research is lagging" (Vrakas, 2020, para. 5) and in an article for the *National Post,* a different physician directly pitted psychiatry against another branch of medicine, stating that "cardiologists know how heart disease works. But psychiatry hasn't elucidated the pathophysiology of depression or schizophrenia" (Faruqui, 2022, para. 35). In addition to questioning the scientific legitimacy of the discipline, experts also raised concerns about the moral capability of psychiatrists themselves to participate in MAiD, further denigrating the discipline.

Psychiatry was historically marked as an authoritarian institution and has come under moral attack for policing social deviance and the continuing presence of coercion within the psychiatric system (Busfield, 2014; Rose, 2018). Similar concerns emerged from my dataset. Some experts raised psychiatry's involvement in horrifically unethical medical practices such as eugenics and forced sterilization to assert that the discipline could not possibly participate in such a morally fraught practice. Others drew on data from Belgium to argue that a small number of psychiatrists would facilitate an inordinate proportion of MAiD deaths (Kim and Lemmens, 2016; Maher, 2020a). Ultimately, these experts questioned psychiatry's moral capacity to participate in MAiD given its ethically troubled past and perceived need to prove itself as a medical discipline.

I maintain that experts on all sides of the debate, intentionally or not, weaved a critique of psychiatry throughout the clinical ethics-based discourses that emerged from my dataset. Some proponents criticized the discipline as failing to acknowledge the limitations of medicine and claimed that such ignorance reflected a hubris among psychiatrists. They argued that the legalization of MMS would force the discipline to acknowledge its limits, thus fostering its integration into the mainstream of medicine which would, in turn, enhance the profession's legitimacy. By contrast, several opponents critiqued the lack of evidence and troubled ethical history of the discipline to argue against permitting MAiD for mental illness. Experts criticized the discipline to support their respective positions on MMS, thus highlighting its enduring contentiousness and reinforcing its marginal status in medicine. The consistent distinction between psychiatry and "the rest of medicine" raises questions around its place in healthcare and highlights a clear need to reassess psychiatric care in Canada.

4.4. Chapter Summary

Clinical ethics-based discourses revealed dissensus among experts over how to chart the way forward with Canadian mental healthcare, and whether MMS would undermine or strengthen psychiatry's ethical commitments and standards of care. They disagreed over the role of psychiatry – to prevent suicide or alleviate suffering – and over how to classify MAiD – as suicide or a medical intervention. Experts also had differing opinions on what therapeutic approaches MAiD might represent and how MMS would impact the therapeutic relationship. Some portrayed the practice as patient-centered care and argued that it would benefit the patient-psychiatrist relationship. Others argued that the patient-psychiatrist relationship would suffer because MMS is not evidence-based care.

Underlying these discourses on all sides of the debate was a critique of contemporary psychiatry.

As an extension of mental illness, psychiatry is a critical object in the MMS debate. In the documents I reviewed, both proponents and opponents often referred to psychiatry and offered criticisms of the discipline to argue their respective positions. Proponents used the marginalized status of psychiatry as a reason to legalize MMS, arguing that it would bring the discipline into alignment with the rest of medicine. Alternatively, opponents used its precarious status as reason to prohibit the expansion of assisted dying in Canada, arguing that psychiatry's incomplete understanding of mental illness and contentious reputation meant that it could not responsibly participate in MAiD.

The prominent focus on psychiatry in the expert debate is striking as it suggests that the controversy around assisted dying for mental illness is, at least partially, driven by professional divisions and the so-called "civil war", rather than purely by the etiology and prognosis of mental illness and/or patients' suffering. It also highlights some problems and contentions around psychiatric care that move far beyond issues of assisted death. Although the future of MMS is uncertain, I contend that navigating the changing legislative landscape will require robust conversations about the state of psychiatry and the future of mental healthcare in Canada.

CHAPTER 5: CONCLUSION

In the years since medical assistance in dying was introduced in Canada, the practice has been fraught with controversy. There is ongoing debate about under which circumstances and for which conditions, if any, MAiD should be an option for Canadians. This thesis set out to describe and analyze expert discourses surrounding the prospect of assisted dying for mental illness in Canada. In addition to identifying some of the dominant discourses guiding the expert debate, I sought to examine the various arguments for and against MMS. Despite my original intention to investigate conceptualizations of death and dying and Canada's evolving death system, there was a conspicuous absence of death in the documents I reviewed. Instead, the language through which the debate is conducted yielded significant insight into experts' conceptualizations of mental illness and psychiatry. Hence, my study found that the debate served not only as a forum for experts to discuss MMS, but also to consider larger questions and contentions about Canada's mental healthcare system.

As described at the outset of this thesis, experts have become a regular presence in policy making across a range of important issues (Christensen, 2021). Indeed, experts engaged with the issue of MMS are a key category of actors providing MAiD decision-makers with input. They also reach the larger public by publishing in academic journals and digital media forums, such as newspapers and magazines, and by releasing and responding to position statements. My analysis demonstrates how experts might influence the parameters of the debate by concentrating on certain themes or frames while obscuring or leaving out others. For example, the arguments that emerged from my dataset tended to focus on life and emphasize how society treats the living, rather than death and dying.

Moreover, experts drew attention to the legal rights and clinical ethics of MMS, turning attention away from other considerations, such as political and religious facets of the debate.

Rights-based expert discourses highlighted the critical role played by human rights and the *Charter* in the deployment of arguments for and against MMS. Experts drew upon Canadians' right to choose, to healthcare and social supports, to non-discrimination, and associated values – autonomy, vulnerability, and equality – to construct various framings of the practice. Clinical ethics-based discourses shifted attention away from the courts and toward the clinic, where experts debated the role of psychiatry and best approaches to caring for people with mental illness. Disagreement over how MMS might impact psychiatry's ethical standards of care emerged through discussions about whether to classify MMS as a medical intervention and the importance of patient-centered and evidenced-based care. Although I chose to present these two overarching frames separately, they inevitably overlapped, intersected, and even contradicted each other to construct a more complete picture of the debate.

Autonomous choice, rejecting inherent vulnerability, a parity perspective, alleviating suffering, and *patient-centered care* functioned collectively to construct MMS as a positive and progressive step toward promoting human rights and improving care for people with mental illness. Through these discourses, experts framed MMS as an inherent human right. Adding to existing anthropological literature on aid in dying as an ethics of care, experts framed MMS as a compassionate solution to an irremediable medical problem; as a form of quality care for persons struggling with intolerable mental suffering. These discourses also depicted mental illness as similar to other, MAiD-eligible medical conditions (i.e., physical illness) and used psychiatry's marginalized status as justification for legalization of the practice. Because experts hold a significant status in the public, professional and institutional realms, these pro-MMS discourses have the potential to transform perceptions of mental illness and the structures that reproduce discourses of incapacity, vulnerability, and paternalism. Alternatively, anti-MMS discourses relied on and reinforced assumptions of vulnerability and psychiatry's precarious status to argue for the continued exclusion of mental illness from MAiD eligibility.

Privileged autonomy, protect the vulnerable, an ableist amendment, preventing suicide and *evidence-based care* were central legitimising discourses in the prohibition of MMS. These discourses constructed MMS as a rights-violating, ableist, suicide-enabling and eminence-based policy that sits in direct conflict with the mission and morals of psychiatric practice. Expert opponents argued that legalizing MMS would negatively impact people with mental illness in a multitude of ways, notably, by compounding with existing inequities and stigma, thus enhancing their vulnerabilities and endorsing death. Within these discourses, mental illness was consistently distanced from other medical conditions to advocate for the continued prohibition of MMS. More specifically, experts argued that fundamental differences in the nature and treatment of mental and physical illness conditions, like capacity, remediability, treatment length and goals, justified the exceptionalization of mental illness in this context. MMS was also constructed as being mutually exclusive with respect to improvements in healthcare and social supports for people with mental illness.

Taken together, I argue that these overarching frames and dominant discourses both shape and reflect a larger contentiousness around the nature and management of mental illness in Canada. Whereas expert proponents often emphasized the biomedical aspects of mental illness, some opponents appeared to reject psychiatry's dominant model of mental distress. Opponents' emphasis on the association between poor social determinants of health and mental illness depicted mental suffering as being fuelled by social conditions, rather than as a direct product of mental illness alone. They described cases of mental illness, such as depression and anxiety, as both a consequence of social suffering and a form of social suffering itself and tended to adopt a more ecosocial (Kirmayer et al., 2015) or externalist (Maung, 2022) approach to mental illness, which offers a way of looking at mental phenomena as emergent from interactions between bodies, persons, and their environment. Indeed, experts cited access to housing, income, and food supports, for example, as factors that could mitigate requests for MMS. Therefore, I contend that expert discourses reflect a larger trend toward at least a partial demedicalisation of mental illness. In addition to speaking to the complexities of mental illness, expert MAiD-talk also reinforced the precarious position occupied by psychiatry in the hierarchy of medicine.

In *Our Psychiatric Future,* Rose (2018) argues that "to think of mental illness or mental health inescapably places us in relation with psychiatry" (p. 1). Indeed, psychiatry was a recurrent and prominent object across my dataset. Experts on all sides of the debate evoked psychiatry in their arguments for or against MMS. Unexpectedly, an underlying critique of the discipline was used to support their respective positions on the issue. As described earlier in this thesis, psychiatry's dark history – of abuse and oppression - has made both the profession and its critics especially wary of introducing a death-causing intervention into the practice wheel. On one hand, opponents cited psychiatry's marginalized status and "lagging" scientific knowledge about mental illness as reason to continue prohibiting access to MAiD for such conditions. On the other hand, proponents used these same reasons as rationale for moving forward with legalization, arguing that allowing people with mental illness to access MAiD would force psychiatry to acknowledge its limitations, thus bringing the discipline into ideological alignment with the rest of medicine as well as possibly increasing access to mental health services. As the demand for mental health services continues to rise, the MMS debate offers an important opportunity to re-open a national conversation about the state of psychiatry in Canada.

Considering the intense discord surrounding mental illness and psychiatry, I maintain that the discourses that emerged from my study ultimately combine to expose a larger call for a reassessment of mental healthcare in Canada. If we remove the explicit focus on MAiD, these discourses are telling of an inadequate mental healthcare system that requires change of some sort – whether that be implementing MMS, improving access to care, strengthening suicide prevention programs, investing in advancing psychiatric science, or some combination of these. In other words, the debate highlights some profound dilemmas in Canada's management of mental illness.

In a chapter titled *Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years,* renowned anthropologist Arthur Kleinman predicted that emphasis will "shift from psychiatric medicalization to the relationship between psychiatry and social suffering" (Kleinman, 2012, p. 183). My study shows that there is tension between experts who wish to ground psychiatric practice within biomedicine and those who seek to distance the two. Whereas proponents were eager to foster change by treating mental illness like any other medical condition and aligning psychiatry with other branches of medicine, opponents sought to sustain a sharp distinction between mental and physical illness and shift away from a purely biomedicalised model of mental illness and care, toward one that acknowledges and better addresses the social roots of mental suffering through improved access to social supports in conjunction with quality medical care.

To rethink psychiatry's foundations as well as the moral dimensions of policy and clinical practice requires an understanding of the ways in which values and assumptions are woven into the normative language used in the MMS debate. The experts included in my dataset evidently sit in the midst of multiple, competing viewpoints and tensions. As mental health issues continue to rise in Canada, and psychiatric wait times get longer, mental illness has become an increasingly debated topic. MMS is certainly a prominent public problem, and this study demonstrates how the debate functions as a discursive space in which many of the core tensions and conflicts of mental illness and psychiatry are being negotiated. As such, it is worth questioning whether this is the optimal context - interwoven between assisted dying consultations within Canadian courts - within which to be debating such fundamental issues. After all, Rose (2018) maintains that "transferring authority to lawyers and legal institutions in the name of civil or human rights is an inadequate strategy for generating radical reform of a contemporary mental health apparatus" (p. 175).

Although my key findings centre around the contentiousness of mental illness and psychiatry, my study also adds to the anthropological literature that challenges perceptions of aid in dying as being wholly focused on the individual. Other scholars have pointed out that many "progressive" arguments in favor of assisted dying engage neoliberal values, such as individualism, self-responsibility, freedom, and rationality (see for example, Booth & Blake, 2020; Sikka, 2021). Although experts across my dataset did invoke notions of individual rights, freedom and choice to advocate for MMS, their strong articulation of social responsibility for healthcare and the management of mental suffering, for example, is not a particularly neoliberal argument. Moreover, experts clearly displace agency onto medicine and the state to facilitate or prevent death and emphasize the important role of social and health policy in the face of profound human suffering.

As stated earlier in this thesis, MAiD would not be possible without an evolution in the history of ways of approaching and conceptualizing death and dying. Indeed, the medicalisation of death, notions of a good death and increasing individualism underpinned several arguments presented in favor of MMS. For example, experts in favor of MMS constructed MAiD as an essential part of quality medical care and stressed the importance of psychiatry's involvement, rather than absence, in their patients' deaths. They also depicted MAiD as a better and less traumatic death than suicide. and relied on notions of individual freedom and autonomy to advocate for the "right to choose".

Nevertheless, some of the discourses that emerged from my dataset seem to challenge the various cultural scripts that support Canada's death system and medically assisted dying. For instance, despite discussions about mental suffering as stemming from social factors, the notion of social death did not seem to be applied in the same way for mental illness as it has been for cases of physical, terminal illness (see Norwood, 2020 for example). It is interesting to consider why this might be, and whether it is linked to other tensions in the debate such as remediability and/or access to treatment. Furthermore, when discussing MMS, many experts engaged with the idea of a meaningful life rather than the 'good death' discourse common to assisted dying rhetoric. While opponents argued that society should focus on helping people live better, as opposed to dying well, some proponents claimed that the option of MAiD could provide patients with access to better quality mental healthcare, in turn improving their quality of life and promoting a desire to continue living. As the debate continues to rage on, it is worth investigating whether the focus on life, rather than death, reflects a deeper issue surrounding Canada's commitment to care for those living with mental illness.

As I neared the completion of this thesis, the government announced its decision to delay the implementation of MMS for an additional year, indicating a clear lack of consensus on the issue. If or when MMS is implemented in Canada, there will be endless opportunities for research. Nevertheless, the uncertainty exposed by the delay also reflects a need for further investigation into the phenomenon, to assist Canadian leaders in determining how to progress in the face of such a polarizing issue. Moreover, with the delay, it is possible that discourses will shift and emerge as new evidence or arguments are introduced in the debate.

My thesis focused on a specific subset of experts involved in debates about MMS and provided an overview of a variety of emergent themes, frames, and discourses. Although an array of experts will continue to play a significant role in defining the parameters of the debate, this focus offers but a glimpse into the overall debate because it excludes a number of actors who are equally involved in the construction of MMS. A critical yet relatively unexplored avenue for research involves the investigation into patient perspectives. People with lived experience of mental illness' voices have been largely neglected in these debates, and also historically. To abide by the "nothing about us without us" ethos of ethically sound research, it is crucial that future studies engage with this demographic: the people who will be directly impacted by the continued prohibition or legalization of MMS. Another potential avenue of research would be to dive deeper into some of the specific themes and discourses that emerged from this study or to conduct comparative studies. For example, investigations into vulnerability-based arguments for and against the practice could further elucidate perceptions of people with mental illness and influence policy-design. A cross-cultural comparison could also yield important results.

As described in the introductory chapter of this thesis, the goal of my study was to elucidate the overarching frames and discourses driving the MMS debate among experts. Therefore, my analysis paid little attention to who said what and where. However, this is not to say that there are not critically important findings to be uncovered by comparing MMS arguments both between and within categories of experts. For example, it would be worth investigating why psychiatrists who regularly use the DSM and whose research focuses on the biochemistry of mental disorders rely on the social determinants of mental health when making arguments about MAiD or why a mental health professional working for CAMH might have a different opinion, and perhaps different interests, than a psychiatrist working as a university professor.

Another matter worth further consideration is how psychiatric medicalisation might intersect with the issue of MMS to produce consequences that may not be in patients' best interests. Recent decades have seen increasing demands for diagnosis and the recognition of new forms of diagnosis as a reaction to the proliferation of psychiatric categories in each successive DSM (Shorter, 2020). There has been a simultaneous rise in discourses surrounding over-diagnosis, whereby psychiatry has been criticized as pathologizing 'normal' aspects of human life (see Horwitz, 2002 for example). Likewise, expert opponents across my dataset raised concerns that should MMS become legal, MAiD would be offered to individuals suffering with social problems (e.g., grief and insecure housing). As the DSM expands, so too might the number of experiences that would qualify for MAiD.

The "disease like any other" tagline conceptualizes mental illness as having primarily biogenetic causes and has been a big campaign for psychiatry for several decades, driving anti-stigma programmes and forming part of the argument for increasing genetic and neuroscience research efforts (Malla et al., 2015). There is, incidentally, an interesting parallel here as well, that many pro-MMD discourses depict mental illness as the same as any other medical condition to advocate for its inclusion into MAiD eligibility. This interesting confluence between biomedicalization and MAiD thus begs the question: Could part of the push to legalize MMS be motivated by a defense of biopsychiatry and the pharmacological industry, rather than concern for patients?

As argued by sociologist Busfield (2014), the contribution of sociology and anthropology to our understanding of mental illness is "above all, to challenge the belief that psychiatric interventions are value free and to illuminate the way in which existing ideas and practices about mental disorder are shaped by social, political, and economic forces" (p. 371). Indeed, my study reveals the various ways in which conceptualizations of MMS, and by extension, of mental illness and psychiatry, both shape and are shaped by socio-cultural forces. As such, my study also demonstrates the powerful potential for the debate to have a much greater impact by influencing the cultural conversation about mental illness. Entwined in the debate about rights and ethics are some of the fundamental problems that plague the discipline and practice of psychiatry. As experts continue to weigh in on MMS, one thing is clear: assisted dying cannot be isolated from broader considerations of mental healthcare in Canada.

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APPENDIX A – PROTOCOL FORM 1

Document title Has this document been referenced in any of the other texts under analysis? If yes, which one(s)?	
Document type & source E.g.: News article, Toronto Star	
Author(s)	
Type of expert (e.g., lawyer, physician, etc.)	
Publication date	
Overall position on MMS	
Arguments used to support the overall position	
Document summary	
Miscellaneous	

APPENDIX B – PROTOCOL FORM 2

Document title Has this document been referenced in any of the other texts under analysis? If yes, which one(s)?	
Document type & source	
Author(s)	
Type of expert (e.g., lawyer, physician, etc.)	
Publication date	
Overall position on MMS	
Arguments used to support the overall position	
Document summary	
Layout and structural organization	
Objects • Main objects • Marginal objects	
Actors	
Language, grammar & rhetoric • Vocabulary used to refer to assisted dying and mental illness • Key concepts • Buzzwords/catchphrases • Metaphors, rhetorical figures and persuasive devices • Writing style	
Discursive strategies	
Ideological standpoint	

• Does the author appear to be a proponent or opponent of MMS? • What is the author's tone toward MAiD in general? Toward people with mental illness? Toward psychiatry?	
Comparative-synchronic analysis	
Historical-diachronic analysis	
Miscellaneous	
Researcher reflection of article	

APPENDIX C – DOCUMENTS EXAMINED

Commentaries:

Bay, M. (2017). The Devil is in the Details: Thoughts on medical aid in dying for persons with mental illness. *Journal of Ethics in Mental Health*, *Open Volume 10*, 1-6. https://jemh.ca/issues/v9/documents/JEMH%20final%20Reflection-ii.pdf

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