COMMENTARY

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Commentary on "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders"

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Commentary in Response to: "Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders" by Charland, Lemmens, & Wada

Charland et al. (2016) have provided a short but remarkably detailed analysis of the multiple, intersecting issues related to "decision-making capacity to consent to medical assistance in dying (MAID) for persons with mental disorders". The very title of their paper highlights the fact that discussions related to proposed legislation in Canada have their origins and foundations in multiple domains. That is, debate about the provision of MAID has struggled, and will continue to struggle, with a "hierarchy" of issues that include: (1) general principles, (2) constraining factors, (3) standards of practice, and (4) research evidence related to providing for availability and accessibility of MAID within Canada.

General principles

Charland et al. (2016) identify and discuss "individual autonomy" as the dominant philosophical and legal principle underlying the provision of MAID within Canada. Taken to its ideological limits, this principle argues for unrestrained access to MAID for all citizens.

Constraints

Debate concerning MAID has identified an array of issues that might constrain the general principle of universal access to MAID. These constraints include geographic accessibility and age-related accessibility. However, as discussed by Charland et al. (2016), proposed legislation in Canada is struggling with two issues that function as major constraints on the general principle of individual autonomy, namely: (1) the role, criteria and assessment of "informed consent" in decision-making as a general principle, and more problematically (2) particular challenges related to "informed consent" in the provision of MAID for those suffering from "mental disorders". Charland et al. (2016) focus their attention on this latter more challenging constraint.

In the context of decision-making by those with "mental disorders", the authors provide a brief but detailed discussion of (1) issues associated with understanding the complexities in defining and diagnosing mental disorders, (2) providing treatment for mental disorders, and palliative alternatives, that might ameliorate the need and demand for MAID and, most significantly (3) operationalizing the principles of "individual autonomy" and "informed consent" within the context of the provision of MAID for those suffering from "mental disorders".

Research associated with the provision of MAID

Charland et al. (2016) give considerable attention to research evidence related to the provision of MAID in general, and with respect to those with "mental disorders" in particular. Contrary to what might be a prevailing expectation among lay and professional groups, the authors point to the paucity of good evidence related to: (1) consistency in the diagnosis of mental disorders, and (2) the psychometric properties (i.e., validity and reliability) of instruments employed in assessing mental disorders in general, and in assessing the mental capacity/competence related to decision-making by those with mental disorders. The lack of supporting evidence is particularly problematic (1) if, on the basis of the principle of individual autonomy, MAID is made available to those with mental disorders, and (2) if, on the basis of the principle of informed consent in decision-making, an assessment of the individual's mental capacity/competence is required.

Standards of practice associated with the provision of MAID within Canada

Charland et al. (2016) provide limited but important attention to issues related to the standards of practice related to how MAID has been implemented internationally, that is: ***who*** has been involved in implementing MAID policies and procedures, ***how*** and ***when*** MAID initiatives have been implemented, ***what*** form MAID interventions have taken. The authors have identified a number of challenging issues arising from their analysis of international MAID experiences.

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Decision-making by persons with mental disorders

In an effort to advance discussion and understanding of the issues related to the provision of MAID within Canada, the present commentary will provide a "decisional making flow-chart" that attempts to capture the complexity of decision-making regarding MAID. As will be seen, this will incorporate individual decision-making by the MAID "client", ***and*** the role of decision-making by the client's stakeholders (i.e., professional care-givers, substitute decision makers, family members, etc.).

In addition, this commentary will provide and discuss a model that identifies the complex individual, social, and cultural factors that influence individual behaviours; these factors will include both cognitive factors (i.e., knowledge, understanding, and "rational" decision-making) and affective factors (i.e., feelings, attitudes, and values).

Figure 1, below, provides a visual summary of major steps in making decisions concerning the provision of MAID to those with mental disorders. These steps reflect the requirements and limitations identified in the proposed Canadian federal legislation related to MAID (i.e., Bill C-14). These steps involve: (1) ensuring that the "client" meets the basic criteria for receiving medical assistance in dying (i.e., an adult, entitled to medical services in Canada, suffering from a "grievous and irremediable condition", and (2) ensuring that the person possesses the mental competence/capability to make free, informed decisions related to requesting medical assistance in dying (see http://justice.gc.ca/eng/cj-jp/ad-am/legis.html) .

In providing their detailed assessment of problems associated with the assessment of decision-making by those with mental disorders, Charland et al. (2016) identify significant challenges that exist in methodological, theoretical, ethical, and philosophical domains. Figure 1 includes references to a few of Charland et al.'s (2016) contributions to our understanding of these issues, among which are:

1. Regarding the central question: "When, and under what circumstances, does a person seeking MAID have the mental capacity to decide to choose and consent to such a medical intervention?" (Charland et al., p. 3)

2. "...the determination of decision-making capacity is actually a matter of considerable controversy among many researchers and clinicians." (Charland et al., p. 3).

3. "It is doubtful that our current knowledge and practices governing the determination of decision-making capacity will be able to bear the weight of the new federal legislation." (Charland et al., p. 4)

4. "...there already exist concrete, documented, controversies of the kinds of challenges that would likely arise if the federal government were to proceed with the proposed extension of the Quebec law on MAID and extend it to cover persons diagnosed with mental disorders. (Charland et al., p. 4).

5. The challenges fall in four different areas: methodological, theoretical, ethical, and philosophical." (Charland et al., p. 4).

Figure 1: Decision-Tree Related to the Provision of Medical Assistance in Dying For Persons with Mental Disorders

(With special reference to Charland, Lemmens & Wada (2016), "*Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders*")

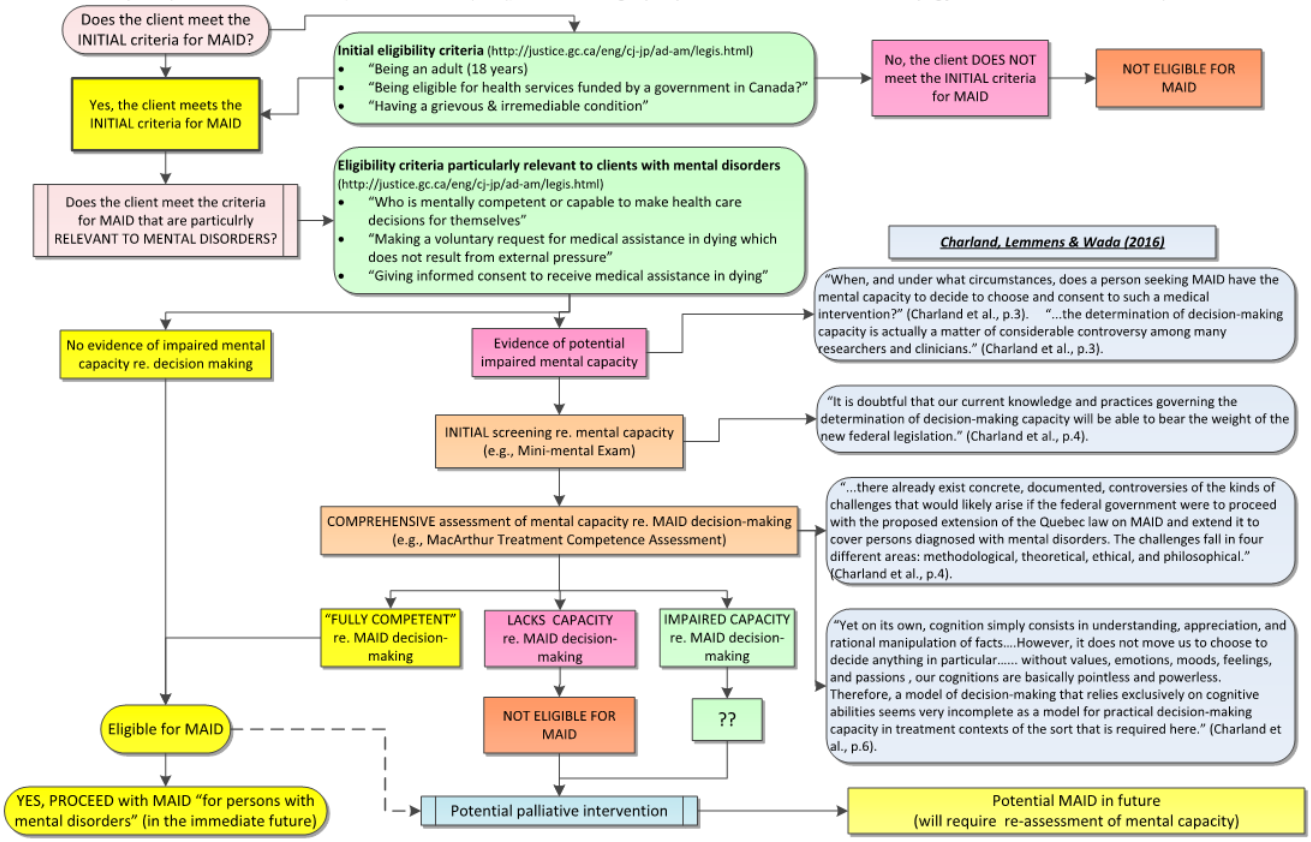
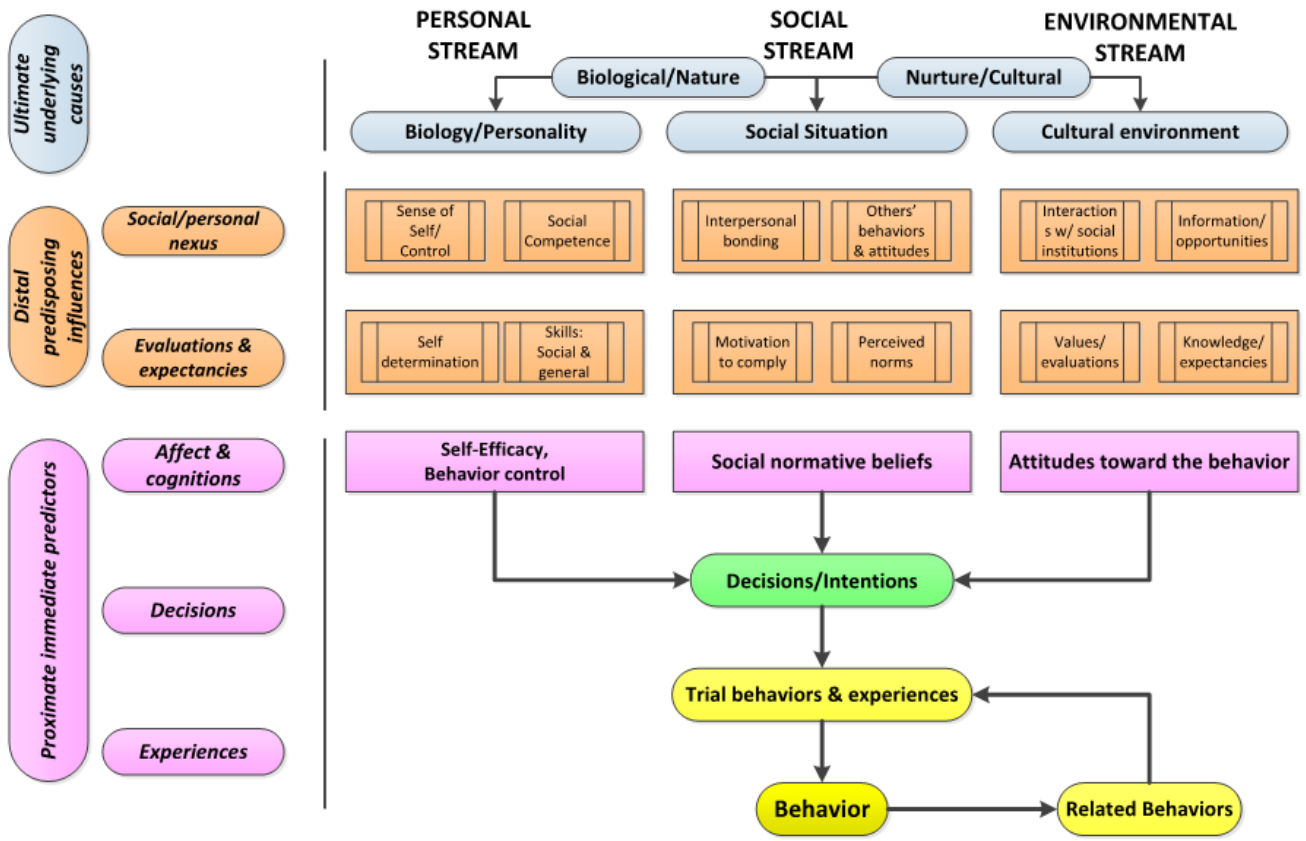


Figure 2: The Theory of Triadic Influence
(Flay et al., 1994, 2009, 2012; Snyder & Flay, 2012)



6. "Yet on its own, cognition simply consists in understanding, appreciation, and rational manipulation of facts….However, it does not move us to choose to decide anything in particular…... without values, emotions, moods, feelings, and passions, our cognitions are basically pointless and powerless.

7. Therefore, a model of decision-making that relies exclusively on cognitive abilities seems very incomplete as a model for practical decision-making capacity in treatment contexts of the sort that is required here." (Charland et al., p. 6).

In discussing theoretical challenges associated with assessing decision-making capacity, Charland et al. argue strongly against the inherent bias in the law that "focuses on the cognitive abilities that underlie decision-making and reasoning" (p. 6). They argue for an extended understanding of human decision-making, especially as this applies to end-of-life decision-making by those with mental health problems. Charland et al. conclude, "So, apparently both the affective components of decision-making [i.e., emotions, feelings, moods, passions] and our values are inextricably involved in practical decision-making. They influence, motivate, and direct our preferences and express what is meaningful to us and why. As such, they are fundamental and one would think ineliminable from medical treatment decision-making, especially decisions to request and consent to MAID." (Charland et al., p. 5).

Conceptual Model of Factors Contributing to Behaviours: "The Theory of Triadic Influence" (Flay et al., 1994, 2012)

Psychologists have long struggled with the kinds of challenges presented by the proposed legislation to make "medical assistance in dying" available to Canadians. In this context, academic psychology is replete with conceptual and theoretical "models" that attempt to describe, explain, and predict individual, group, and societal behaviours and behaviour change (see, for example, Glanz et al., 2008; DiClemente et al., 2009). Among the most widely accepted models of behaviour change are those that incorporate a range of cognitive factors (e.g., knowledge, awareness, understanding) and affective factors (e.g., attitudes, values, emotions). The most powerful of these models include an assessment of factors that lie beyond the individual, that is, that include the fuller socio-ecological array of factors associated with interpersonal, societal, and cultural factors (e.g., Salis et al., 2008).

Flay et al.'s *Theory of Triadic Influence* (Flay et al., 1994, 2009, 2012; Snyder & Flay, 2012) is perhaps the most ambitiously comprehensive of this family of psychological models. As can be seen in Figure 2, The *Theory of Triadic* (TTI) attempts to incorporate an extra-ordinarily wide-ranging array of factors that contribute to behavioural decision-making (i.e., behavioural intentions and behaviour itself); Flay et al. have also gone to great lengths in exploring the complex interacting relationships among the factors that contribute to behavioural outcomes.

Flay et al.'s *Theory of Triadic Influence* provides a caution against employing an oversimplified, single-dimension (i.e., exclusively cognitive), understanding of issues associated with assessing the decision-making capacity of those with mental health disorders; the model provides a template for understanding and assessing individual and societal decision-making concerning medical assistance in dying.

Conclusion

We have provided a brief commentary on Charland et al.'s (2016) convincing critique of the proposed Canadian legislation regarding the provision of medical assistance to the general population, and to those with mental disorders in particular. Our discussion has focused on the complexities involved in satisfying the proposed legal requirements that MAID applications reflect truly voluntary and informed decisions. We have provided a conceptual time-line of the processes involved in making these assessments. We concluded by pointing to the complexities involved in all behavioural decision-making. Such complexities present challenges in assessing the voluntary and informed nature of any decisions; it is self-evident that assessing the voluntary and informed nature of decisions made by persons with mental disorders will be especially problematic.

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