Toronto General Hospital
University Health Network

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TESTIMONY TO SENATE COMMITTEE IN REGARDS TO BILL C-7

My name is Dr Donna Stewart MD, FRCPC. I am a University Professor at University of Toronto, a rank awarded to less than 2% of Full Professors. I am a staff psychiatrist at Toronto General Hospital, University Health Network. I practiced as a family doctor in Ontario's far north before qualifying as a psychiatrist nearly 50 years ago. I specialize in psychiatric consultations on mentally and surgically ill individuals who also have psychological difficulties. I held the world's first Chair in Women's Health from 1995-2018. I am a member of the Canadian Psychiatric Association, the Canadian Association of MAID Assessors and Providers and the University of Toronto Centre for Bioethics. I teach in the Faculty of Medicine and conduct research, including on MAID. I have over 400 peer reviewed scientific papers and 4 books published. In 2014 I became a Member of the Order of Canada.
I am speaking to you today in my personal capacity.

I will speak briefly today on several topics related to Bill C-7 and conclude that it is my considered opinion that individuals who suffer solely from mental disorders and meet the criteria of Bill C-7 deserve a fair assessment for MAID. To deny this MAID assessment (despite the likelihood that few will qualify) is discriminatory and also appears to contravene Section 15 of the Canadian Charter of Rights and Freedoms.

My following comments relate to topics that have been raised as objections to the inclusion in MAID solely for individuals with mental disorders:

1. Physical vs Mental Disorders: This is a false distinction in the concept of illness as there is great overlap between these conditions. Many physically ill individuals suffer from sadness and depression (1). The brain is a physical organ and research shows abnormal functioning in most mental illnesses. Depression and other mental illnesses may cause physical symptoms and conditions such as heart disease. Physically and mentally ill individuals alike can experience grievous, intractable and intolerable suffering.

2. Incurable and Irremediable Condition: Most doctors, including psychiatrists, are optimistic. This serves patients and doctors well! After all, who would want a pessimistic doctor? And hopefulness is itself therapeutic. However, policy must be based on reality not dreams and only a self-delusional doctor thinks (s)he can cure everyone! The best available evidence shows that treatment outcomes for dementia are abysmal (2). For depression, even after 4 switches of antidepressants only 67% of 3671 US patients reached remission (3). A Dutch study of 903 treated depressed patients found 58% had short term recovery, 21% had chronic depression and 6 years later only 17% had recovered (4). In fairness, additional treatment with psychotherapy, electroconvulsive ("shock") therapy, newer neurostimulation techniques (rTMS), ketamine or hallucinogens may achieve slightly better results in highly selected individuals. Long-term outcomes in a variety of other mental disorders such as schizophrenia, eating disorders and neuropsychiatric disorders show a substantial number are irremediable. A review of irremediable psychiatric suffering in the context of physician assisted death explores this issue in greater detail (5).

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3. Capacity/Competency Assessments: All psychiatrists are taught during their training to assess capacity and to determine whether psychopathology or external factors affect this. I have taught this for years. Capacity assessment is needed to obtain consent or refusal of treatment for psychiatric disorders, or for medically ill patients who may refuse life-saving interventions, or demand discontinuation of life-preserving therapy. Psychiatrists may also be asked to assess competency to sign out of hospital against medical advice, activate a power-of-attorney or substitute decision maker, write a Will or agree to donate a vital organ for transplantation. In cases of doubt about capacity, a variety of evidence-based assessment tools can be helpful (6). One study found excellent agreement between psychiatrists for capacity judgements on the same interview (7). All psychiatrists should be able to do a capacity assessment and most do so on a regular basis (8). I understand that family doctors also receive training in capacity assessment.

4. Suicidality: It has been claimed by some that to allow individuals with mental disorders to be assessed for MAID will (i) undermine suicide prevention programs, (ii) increase suicide rates, (iii) allow state-sponsored suicide. Jurisdictions which permit physician assisted death for mental disorders (Belgium, the Netherlands, Switzerland) have (i) active suicide prevention programs (ii) show no increase in national suicide rates and (iii) provide safeguards (discussed later).

5. My Clinical Experience and Research: I have conducted MAID assessments for approximately 200 patients primarily at University Health Network but also a few in the community. Several of these individuals had mental disorders (usually depression) in addition to a life-threatening physical illness. The challenge is to determine whether the depression motivates the request for MAID, and this determination is usually not difficult.
   I have also been asked to assess 3 individuals seeking physician assisted death in Switzerland solely for a mental disorder. None was eligible in my opinion. However, for 2 of these patients I was able to point out gaps in their long treatments that were available to them and which they were willing to pursue. One has now returned to her estranged family and gone back to work. The 2nd is pursuing other treatment (rTMS). The 3rd individual had a personality disorder and was seeking revenge on his estranged spouse. I have also seen a tiny number of patients who would likely qualify for MAID (if they applied) after rigorous comprehensive assessment with safeguards (see below).
   It has been claimed by some MAID opponents that burnout and depression will increase in physicians and nurses engaged in MAID. My research study of 131 MAID assessors and providers from across Canada showed higher levels of resilience than in a national study of US physicians. Moreover, Canadian physicians and nurse practitioners engaged in MAID showed high levels of protective factors such as satisfaction in providing compassionate care, relief of suffering, enhancing patient autonomy, professionally satisfying work and feelings of honour and privilege in providing MAID. (9).

6. Safeguards: It is my opinion that additional safeguards are required for individuals seeking MAID solely for a mental disorder. These should in my opinion include criteria for a comprehensive assessment including (i) duration (chronicity), (ii) severity, (iii) adequate treatment history, (IV) sustained and well considered wish for MAID, (v) consultation with treating teams and (vi) significant others (e.g. family) (10).
   I also think at least one assessor should be a psychiatrist experienced in the evidence-based treatment of the specific mental disorder. Consideration could also be given to creating a small virtual panel who could prospectively examine the documentation and interview the patient to prevent potential abuses. As the majority of applicants will not likely qualify during an initial assessment, the number of

individuals reaching this latter panel stage is likely to be small. (An expert panel modelled on, for example, the Ontario Consent and Capacity Board could undertake this work.)

7. Conclusions: Although MAID solely for mental disorders will require complex considerations, as indicated above, these are not insurmountable. Equitable access to clinical services is essential to ensure that individuals do not seek MAID due to a lack of available treatments or supports.

   In brief, individuals with mental disorders/illness should not be discriminated against solely on the basis of their disability and should have the same options available with respect to MAID as all other individuals.

Thank you for your attention.

Respectfully submitted,

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