February 2, 2021

Brief Submitted to Standing Committee on Legal and Constitutional Affairs

Re: Bill C-7, Criminal Code Amendments (medical assistance in dying)

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Dear Standing Committee,

I am grateful for the opportunity to submit some comments with regard to Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*.

I am a psychiatrist at Sunnybrook Health Sciences Centre in Toronto and Lecturer at the University of Toronto, and I have been a MAID assessor since 2015. I am engaged in MAID research and have published papers on topics related to MAID in the context of mental illness. I have lectured on this topic, and I was an Expert Witness for both the *Truchon* and *Lamb* cases.

I am a member of the Canadian Association of MAID Assessors and Providers (CAMAP), as well as the Canadian Psychiatric Association's MAID Working Group, and the Clinicians' Advisory Council of Dying with Dignity Canada (unpaid role). I am submitting my brief today independently of my involvement with these organizations, and the opinions I am presenting are therefore completely my own.

For the purposes of this brief, I will focus on the proposed exclusion of mental disorders. I would suggest that the exclusion be removed and replaced by a sunset clause which would permit clinicians, ethicists, and legislators to draft reasonable policies, safeguards, and educational modules to assist MAID assessors and providers.

This exclusion is problematic in numerous ways. The exclusion, and the language in Section 2.1, is stigmatizing and may serve to minimize the suffering of individuals with mental disorders as the sole underlying medical condition (MD-SUMC). Furthermore, it is nonsensical to deny that a

mental illness can be a serious illness, disease, or disability. Mental illness can present in diverse ways, with a wide spectrum of severity, and a substantial proportion of individuals with severe mental disorders struggle with immense suffering and disability. The United Nations reported, for example, in 2017, that major depressive disorder is the leading cause of disability worldwide (1), and the WHO estimates a 10-25 year reduction in lifespan in severe mental illness (2).

This exclusion also attempts to separate "mental" from "physical" illness. Given that the brain is a physical organ, with neuroanatomical differences described in numerous psychiatric disorders, and given that there is often comorbidity between "physical" and "mental" illness (3), the exclusion is not only false, but harmful. Just as "physical" illness can have psychiatric symptoms, such as depression in Parkinson's Disease or multiple sclerosis, psychiatric illness can have physical symptoms, such as pain, tension, and gastrointestinal symptoms in mood and anxiety disorders, or as in conversion disorder illustrated by the case of E.F. v Alberta (4).

Similarly, to separate "mental" *suffering* from "physical" *suffering* is also misleading and harmful. Some of the most pertinent evidence illustrating the impossibility of this separation in the MAID context comes from the existing data on reasons for requesting MAID. The most common sources of suffering leading to the request, under current MAID laws, are not "physical." For example, they include psychological and existential distress, loss of independence and autonomy, emotional distress, and the inability to engage in activities the individual considers meaningful. These themes are well described in data from Oregon (5) and Canada (6), and are not specific to "physical" illness.

I would like to address several of the arguments often put forth in favour of an exclusion like the one proposed in Bill C-7. I addressed these kinds of arguments in depth in my Expert Report for the *Truchon* case, and I am happy to provide you with a copy of this report by email if you are willing, given that at this point in time it is in the public domain but not easily accessible online.

1) Arguments that individuals with mental disorders are particularly vulnerable:

Anyone, with or without a mental disorder, has the potential to be vulnerable. Severe physical symptoms like pain and nausea at the end of life, existential distress, abuse or violence, difficult family dynamics, financial stress, and side effects of medications can render any patient vulnerable, when requesting MAID. Given that anyone has the potential to be vulnerable, patients deserve a careful assessment, on a case by case basis. A blanket exclusion on mental disorders will not protect vulnerable individuals.

2) Arguments about suicide contagion:

MAID and suicide are distinct phenomena, and arguments stating that MAID where there is no reasonably foreseeable natural death (RFND), or MAID MD-SUMC, will cause suicide contagion risk conflating these phenomena. There is no good evidence to support this argument. An often-cited paper by Jones & Paton (7) is significantly flawed (8). Interestingly, data from the Organization for Economic Cooperation and Development (OECD) (9), as well as other data arising from the European jurisdictions which permit aid in dying for MD-SUMC, indicate a decline in rates of non-assisted suicide over time (10-11).

MAID assessors and providers already encounter situations regularly where they must distinguish suicidality from a rational request for MAID. Even for patients at the end of life with no diagnosis of a mental disorder, suicidal ideation is possible. Where there is suicidal ideation, most physicians, and especially psychiatrists, are trained to assess suicide risk. Furthermore, capacity assessments for MAID are already routinely conducted for patients with comorbid physical and mental disorders. The types of complexities that can arise in these capacity and eligibility assessments are already being dealt with by MAID assessors and providers. MAID assessment at these times is a very rigorous process, to ensure that patients who are suicidal in the conventional sense do not get approved for MAID.

It goes without saying that we should continue to research the impact of MAID and to respond appropriately to important findings. It also goes without saying that suicide prevention should always be a top priority, and, certainly, the government should continue to bolster funding and efforts toward suicide prevention. I wholeheartedly agree with the witnesses who are advocating for expansion of publicly funded mental health and suicide prevention resources. And I also believe that this can be done alongside the existence of MAID laws.

3) Arguments about capacity and cognitive distortions:

It has been argued that individuals with mental disorders are less likely to have capacity for MAID, for several reasons, including the potential impact of the disorder on the wish to die (for example, the fact that suicidal ideation is listed as a symptom of major depressive disorder and borderline personality disorder in the DSM-V) (12). Similarly, arguments have been made that individuals with mental disorders harbour cognitive distortions which may unduly affect their decision-making even if they meet legal criteria for capacity (13).

Regarding the former argument, it is important to keep in mind that the government has already accepted that a request for MAID can be rational, capable, and voluntary. Although a desire to die can be a symptom of a mental disorder, it is by no means always simply a "symptom," and to assume that it is in all cases serves to undermine the autonomy of these individuals. Individuals making the request for MAID for MD-SUMC should have the same right to a thorough assessment of eligibility (which includes assessment of capacity and rationality) as anyone else making the request.

Regarding the latter argument, there exists no empirical data on the impact of cognitive distortions on medical decision-making, not only where MAID is concerned but for any medical decision (14). This certainly deserves further study, but it cannot be used as a reason for a blanket exclusion. Additionally, it is important to keep in mind that all human beings experience

cognitive distortions, whether or not they have a diagnosed mental illness (14). Anyone requesting MAID may harbour cognitive distortions that could affect the decision, and so to exclude only those with sole mental disorders on these grounds is discriminatory.

Furthermore, where comorbidity is concerned, it is important to recognize that under Bill C-14 thus far, and under Bill C-7 moving forward, individuals with comorbid physical and mental disorders are already permitted to request MAID. This means that, already, capacity is being assessed on a regular basis, where mental disorders are present. Psychiatrists have already been conducting these assessments; excluding sole mental disorders will not remove the challenges that already exist in these assessments.

4. Arguments about uncertainty about prognosis and/or determination of irremediability

It has been argued that the exclusion in Bill C-7 should be upheld because the prognosis – or degree of "irremediability" - of individuals with mental disorders is more difficult to determine than in physical illness. I can appreciate the concern voiced by some witnesses, that even if we have access to statistics on recovery rates in mental disorders, these statistics are flawed because they are based on studies that review a limited amount of data (ie. only psychopharmacological or biological interventions, or that these studies are not sufficiently long-term in their scope). That said, I believe that even if further research could yield more definitive statistics, we would still be faced with the fact that it would be impossible to determine, with 100% certainty, whether each single individual may have an irremediable illness. However, this same challenge already exists in the prognostication of physical illnesses that will be eligible under C-7, such as chronic pain disorders, and certain types of multiple sclerosis. Excluding MD-SUMC does not solve this problem.

I also appreciate the concerns of some witnesses that irremediability is not just about the symptoms of the illness itself, but that a patient's ability to adjust to those symptoms may allow for a reduction in "unbearableness" of suffering even in the presence of an "irremediable" or

or incurable condition. I absolutely believe in trying to help patients find meaning in their suffering, and in trying to help patients to learn to accept the limitations imposed upon them by their illnesses, whenever possible. I do this every day in my practice. I accept, though, based on my clinical experience, that these changes in perspective are not possible for every patient, and that sufficient alleviation of suffering is not possible for every single patient. I would point out that the concepts of acceptance, and of learning to find meaning in suffering, are not unique to situations of mental illness. Under Bill C-14 and C-7, already, patients are permitted to be assessed for MAID even though – for anyone, no matter what the illness or prognosis – there is always a chance of perspective change. A blanket exclusion is, again, therefore, discriminatory.

5. Arguments about lack of access to resources and psychiatric or medical care:

One final point I wish to address is the concern that individuals with mental disorders may be marginalized, and that they may not have had access to appropriate psychiatric care. It is true that access to health care is not fully equitable in Canada, although that is something for which we strive, and for which we should continue to strive. MAID is not intended to replace evidence-based health care; MAID remains a last resort, when an illness is irremediable and suffering is unbearable. Safeguards, such as the requirement for "irremediability" and "irreversible decline in capability" already serve to ensure that adequate treatments have been offered. I am in favour of creating additional safeguards relating to how we choose to define "irremediable" in mental disorders, but I am not in favour of a blanket exclusion for the reasons outlined above.

In my clinical experience as a MAID assessor, in situations where mental illness is present, the request has led to a thorough psychiatric assessment (the MAID assessment), as well as to access to new and additional resources and referrals. I believe that the ability to make a MAID request can at times lead to improved access to resources, and it can even at times open up new therapeutic avenues.

In conclusion, I would like to speak from my own clinical experience. As a MAID assessor, I am extremely cautious. When I assess a complex patient, and if I have any doubt in my mind as to eligibility, I consult with colleagues – often more than one. I ask for second opinions, or third opinions, when needed. I also meet the patient multiple times, rather than jumping to a conclusion. I research alternative treatments and options, to ensure that the patient has been given access to all appropriate resources. If the patient has refused an intervention, I ensure they had capacity with respect to that decision. I consult with specialists in the patient's medical condition. I never take a MAID request lightly, and I often feel perplexed when those opposed to MAID where mental disorders are present seem to assume that assessors like myself would simply bow to a patient's request without exercising caution. In my view, MAID is about nothing other than valuing life – valuing quality of life – and I value life deeply. I also recognize that in some cases, life can be unbearable without much prospect of relief, and I respect that this has the potential to be the case whether the medical condition is categorized as a "physical" or "mental" condition.

I wish to express my appreciation for the opportunity to provide this brief to the Committee. Please feel free to contact me with any questions or concerns.

Sincerely,

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