Senate Brief on Medical Assistance in Dying (MAiD)

Prepared by Dr. K. Sonu Gaind

November 27, 2020

Dear Senators,

Following is a brief regarding key issues related to MAiD and mental illness, including specific recommendations for pending legislation. Also find attached an appendix containing three documents as follows:

- two articles from the Canadian Journal of Psychiatry (the CPA's own peer-reviewed journal) criticizing the lack of engagement and the non-evidence-based content of the CPA Position
- the report of the Expert Advisory Group providing evidence-based review of MAiD and mental illness, in both English and French

In terms of my qualifications and experience regarding MAiD, please see below. I am not a conscientious objector, I am choosing to be involved in MAiD and know the benefits it can provide patients and families.

- clinically, my area of expertise as a psychiatrist is psycho-oncology, in that context I have worked with dying patients throughout my career
- related to national MAiD policy:
  - similar to some other witnesses, I sat on the CCA Expert Panel on MAiD and mental illness
  - I was president of the Canadian Psychiatric Association in 2016 and also Chair of the time-limited CPA Task Force on MAiD 2016-2018, during that time we were actively engaging members and stakeholder organizations as initial MAiD policies evolved
  - also similar to some other witnesses, I was an expert witness in the Truchon case (and was planned as an expert in the Lamb case)
- related to MAiD 'on the ground' implementation:
  - since 2016 I have been our hospital's physician chair for both our MAiD resource group (the clinical group doing MAiD assessments/procedures) and our MAiD steering committee (setting hospital policy on MAiD)
- related to international MAiD policy:
  - I have also been actively involved in MAiD and mental illness issues internationally, having chaired the first World Psychiatric Association (WPA) round table on MAiD in 2016 in Cape Town, and consulting with international psychiatric leaders and presenting sessions on MAiD and mental illness at every WPA congress since

RECOMMENDATIONS:

1. **Bill C7's current exclusion of mental illnesses from consideration as sole criterion applications for MAiD should remain**
    - However, the wording should make it clear that this exclusion is based on inability to fulfill a key requirement, specifically of there being no evidence or standards for predicting irremediability in mental illnesses
    - The wording should acknowledge that mental illnesses can be grievous disorders

2. **There should be *no* "sunset clause" on the exclusion of mental illness**
    - Embedding a sunset clause on the exclusion of mental illness presupposes that it will be possible to reliably predict irremediability of mental illnesses. So far, despite the work of the CCA and others, that has not yet been determined.
    - While there can be further work done studying the potential for being able to predict irremediability in mental illnesses, implementing a sunset clause with the presupposition that irremediability will be predictable is not based on evidence, and in many ways would be no different than implementing MAiD for mental illness now with the expectation that arbitrary standards will be developed, regardless of whether those standards have any legitimate predictive value.
    - While some organizations have indicated they are prepared to develop "standards", these need to be developed through reviewing empirical data and evidence. Arbitrary "standards" developed without evidence would provide a false reassurance that scientific and evidence-based criteria are being met, when they are not.
    - This risk cannot be mitigated by, for example, having provider training, multiple assessors, etc, as some witnesses have suggested. It is a false premise that "training" will help in the absence of valid standards. Multiple people adhering to a sham "standard" does not make it any more accurate or scientific.
    - Any work or study undertaken to determine if irremediability can be predicted in mental illness should be academically honest, without presupposition of outcome, and there should not be any 'sunset' clause presupposing otherwise.

3. **Part of all MAiD request data requirements nationally should include a standardized item to track the nature and degree of suffering motivating the request, using a visual analogue or Likert scale to specifically gauge suffering in the following domains:**

    a. **Physical suffering/symptoms (eg pain, fatigue, weakness, other _____)**

    b. **Psychological suffering/symptoms (eg depression, anxiety, guilt, other _____)**

    c. **Social suffering/symptoms (eg loneliness, poverty, burden to others, other ____)**

    - If MAiD is to be provided for irremediable conditions when death is not reasonably foreseeable, the nature of suffering that motivates MAiD requests is likely to further expand beyond predominantly illness or medical disorder related suffering. Rather than a framework providing death to those who want to avoid a painful death, the framework shifts to those who wish death to avoid a painful life. It would be important to track the nature of suffering motivating requests to understand what suffering people are receiving MAiD for.

4. **For all MAiD assessments when death is not reasonably foreseeable, part of the required data completed by the health provider should be identifying the rationale that irremediability was determined upon, whether through:**
    a. **Known pathophysiology or course**
    b. **Existing standards or guidelines**
    c. **X Clinical opinion X**

    - If MAiD is provided for conditions beyond end of life conditions, it will be important to track the basis that irremediability determinations were made upon. In addition to data tracking, part of this is for accountability of what informed the irremediability assessment.
    - In the above framework, option “A” would reflect empirical evidence, option “B” would reflect normative guidelines. Option C, clinical opinion, is marked with X since clinical opinion in the absence of empirical evidence or normative guidelines should be avoided, as that would expose patients to arbitrary assessments of irremediability.

5. **AMENDMENT: For the "reasonably foreseeable natural death" pathway, a defined time frame should be identified**
    - If a dual pathway model is adopted, with certain criteria for the RFND path and different criteria for a non-RFND path, a defined time-frame, for example anticipated life expectancy of 6 month or 1 year, should be established
    - In the current MAiD framework (pre-C7), it has been established that consideration for MAiD cannot be limited to a defined period of time prior to anticipated death. If there are two pathways, as outlined in bill C7, one pathway (the one when death is not foreseeable) already allows for MAiD applications without any restrictive time period prior to anticipated death.
    - For the RFND pathway to have any meaning in this model, there needs to be greater clarity regarding what a reasonable timeframe is for RFND. The suggestion is to use a time frame consistent with established clinical markers of anticipated death, such as time frames in which people can become eligible for hospice services or similar.

6. **AMENDMENT: For the non-RFND pathway, if there is to be one, that pathway should only be able to be triggered if it is patient initiated**
    - If there is to be a pathway to MAiD for people who do not have RFND, this changes the MAiD framework from one where people seek MAiD to avoid a painful death, to one where they seek death to avoid a painful life
    - Given the societal stigma and other challenges they face, this increases the risk of disabled people with internalized stigma potentially seeking death as a relief from life. Given the power imbalance between patients and health providers, which is often magnified for those who have disabilities, it becomes essential that the idea of MAiD reflects the person's authentic wish and is motivated by their request, rather than the high risk of a vulnerable person in that situation internalizing or perceiving a suggestion or proposal from a health provider

---

Miscellaneous Points Raised During Hearings

Suicide and MAiD

Comments were made about suicide rates since 2002 going down in Belgium by 20% and staying stable in the Netherlands after MAiD for mental illness was introduced (Sen Kutcher, November 24, question to Dr. Mishara). As per the CCA report: "In jurisdictions where psychiatric EAS is permitted, OECD data show that, on average, the non-assisted suicide rate decreased in the Benelux countries between 1990 and 2016 (OECD, 2018). More recently, the suicide rate has increased in the Netherlands since 2007, while remaining relatively stable in Belgium. Generally, suicide rates are decreasing worldwide (WHO,

2014a). There is no evidence of any association between the legal status of assisted dying in a country and its suicide rate: some jurisdictions where assisted dying is legal have higher suicide rates than jurisdictions where the practice is illegal, and vice-versa (OECD, 2018). Suicide rates in any given country are related to a multitude of factors." [page 96]

In any case, another issue of concern regarding suicide and MAiD for mental illness relates to the evidence showing overlap of characteristics between those who apply for MAiD for mental illness, and traditionally suicidal individuals i.e. evidence showing we cannot readily distinguish between these two groups. The concern beyond suicide rates changing is that, if/when traditionally suicidal people apply for and receive MAiD, they will receive a state sanctioned suicide via MAiD (and these numbers would not be captured in 'suicide rates', since while the same person has died for the same reasons, they are now counted in a different category [non-suicide]).

Different Patient Populations

Several witnesses provided reassurances that MAiD data shows that vulnerable populations are not at higher risk of seeking MAiD. As discussed in my speaking notes, these data are based on North American MAiD processes, which so far have been for those with RFND. It is improper to extrapolate from these data that vulnerable populations would not be more likely to seek MAiD if/when MAiD becomes available for conditions outside RFND. As per the speaking notes, existing data show the opposite, that more vulnerable populations do apply for MAiD for mental illness if that is available.

This also speaks perhaps to the narrow scope of consideration or experience of some of the witnesses. For example, Dr. Downar has said on several occasions that he cannot think of situations where the RFND criterion is not met and the other existing criteria are. This clearly reflects a different patient population than those who would potentially seek MAiD if MAiD for mental illness were available. It is difficult to weigh how much weight experience with his patient population should be given, since it is not translatable to the current issues at hand when expansion beyond RFND is being contemplated.

Even Dr. Gupta, a psychiatrist, in describing the patients she is recommending become eligible to apply for MAiD for mental illness and trying to assure the Senator that patients applying for MAiD would have had access to treatments, testified that she was describing patients who have been ill for decades, who have over that time tried many interventions, and indicated that *in her personal experience as a clinician she had met only a very few of these patients*, and that most of them had had access to a wide range of treatments over years and years.

This raises several concerns, including the fact that, while Dr. Gupta tried to reassure the Senator that patients applying for MAiD for mental illness would have tried many treatments, she also reiterated her group's recommendation that it should not be necessary for patients to have tried treatments to receive MAiD. This is highly problematic especially for patients with mental illnesses whose illness symptoms themselves can lead to a lack of hope, and pointlessness in trying effective treatments, even if

previously effective and well tolerated. It also raises highly concerning inconsistencies and questionable scientific validity regarding what Dr. Gupta's group would consider "irremediability", since in discussion it is repeatedly presented as reassurance that only patients who have tried unsuccessful treatment attempts would apply/receive MAiD for mental illness, yet this clearly would not be a requirement under their proposed model.

Canada Becoming the Most Permissive Jurisdiction in the World

Several questions were asked regarding how permissive Canada's MAiD legislation might become, in comparison to other jurisdictions (especially in relation to the Benelux counties). As the CCA found, "No other country permits MAID MD-SUMC where one of the eligibility criteria is based on an individual's personal assessment of what conditions for relief of their intolerable suffering they consider acceptable. If Canada were to expand MAID MD-SUMC using this criterion, it could become the most permissive jurisdiction in the world with respect to how relief of suffering is evaluated." (p 148)

As several witnesses testified, Canada is unique, anywhere in the world, in not requiring that irremediability for eligibility only be assessed once all reasonable options have been tried, or there are no reasonable alternatives, etc.

Canada's sole reliance on the patient essentially determining whether they are irremediable (i.e. even if no reasonable options have been tried, and are likely to help) is inconsistent with medical practice. It is common to require certain preconditions be met prior to patients being able to seek specific treatments. For example, liver transplants are not offered if someone continues drinking alcohol. It is counter to any established practice anywhere in the world to consider that someone with multiple good treatment options, who does not have RFND, could decide to not try any options and somehow be granted a 'right' to MAiD nonetheless.

In consideration of the above issues, and others, the EAG Report additionally made the following recommendations:

CORE EAG RECOMMENDATION
MAiD policy and legislation should explicitly acknowledge that determinations of irremediability and irreversible decline cannot be made for mental illnesses at this time, and therefore applications for MAiD for the sole underlying medical condition of a mental disorder cannot fulfill MAiD eligibility requirements.

ANCILLARY EAG RECOMMENDATION 1
A non-ambivalence criterion should be required for MAiD in situations when death is not reasonably foreseeable.

ANCILLARY EAG RECOMMENDATION 2

*A "lack of reasonable alternative" criterion should be required prior to being eligible for MAiD in situations when death is not reasonably foreseeable.**

*NB: For reasons articulated in Section 3 (iv) of the EAG report, the EAG supports a "lack of reasonable alternative" criterion for all MAiD applications, as is required elsewhere in the world except in Canada. However, this criterion is particularly essential to introduce as current policies change and the "reasonably foreseeable natural death" criterion is rescinded, which is the focus of this critique.

Thank you once again for the opportunity to present at the Senate hearings, and I am happy to connect and provide further information regarding any issues requested.

K. Sonu Gaind