Written Brief to the

Special Joint Committee on Medical Assistance in Dying (MAiD)

Regarding our State of Readiness to Allow Access to MAiD for Those Whose Sole Underlying Medical Condition is a Mental Disorder (MD-SUMC)

Submitted by Dr. Stefanie Green

November 13, 2023

Thank you for the opportunity to submit this written brief to the reappointed Special Joint Committee on Medical Assistance in Dying (MAiD) regarding our state of readiness to allow access to MAiD for those whose sole underlying medical condition is a mental disorder (MD-SUMC).

My name is Stefanie Green, and I am a physician with 30 years of clinical experience. In June 2016, I began working almost exclusively in assisted dying. I am the Founding President of the Canadian Association of MAiD Assessors and Providers, a Medical Advisor to the BC Ministry of Health MAiD Oversight Committee, Co-Lead of the Canadian MAiD Curriculum Project, an international speaker and educator on the topic of MAiD in Canada, and an experienced MAiD practitioner in Victoria B.C. I have no personal or professional stake in the outcome of your deliberations, and I remain committed to providing the highest standard of medical care possible under any and all legislation.

If the purpose of this committee is to "verify the degree of preparedness attained for a safe and adequate application of MAID in MD-SUMC situations", your work should not be complicated. Very clearly, there is a high degree of preparedness, and I point your attention to the numerous readiness activities plainly outlined in the written brief of CAMAP[1] and also referenced by Drs. Mona Gupta and Douglas Grant. There is readiness at the federal level, there are provincial, territorial and regional initiatives that have occurred and continue, and there is preparedness of the medical and nursing regulatory bodies as well as professional associations.

Regardless of what this committee ultimately recommends, I am concerned it be based on fact and not on any fundamental misunderstandings. With that in mind, I submit the following information for clarity:

1. Consensus is not/has never been required in the development of medical practice.

There is no consensus on many medical practices (e.g., hormone replacement therapy for menopausal women, organ transplantation, safe injection sites, use of ketamine for treatment-resistant depression), and this is not taken as a reason or justification to prohibit these practices.

There is no consensus among clinicians about MAiD itself, and yet that did not and does not stop MAiD from being permitted under the law.

Medical practice does not start with training all clinicians before the practice is permitted. Rather, it starts with training some who then, in turn, train others over time. Only clinicians with the professional competence to provide the intervention are

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[1] Readiness Activities Document

permitted to do so – by the standards already published and enforced by the Colleges of Physicians and Surgeons/Nurses[2] in every province and territory.

Any suggestion that consensus is required before moving forward with MD-SUMC is opposition to MAiD disguising itself as a benchmark.

2. Legislation is clear regarding MAiD eligibility.

We need to stop focusing our attention on a person's diagnosis (whether a mental disorder or otherwise) and instead look to the clearly outlined eligibility criteria: the condition must be incurable, irreversible, unrelievable.

Clinical understanding of MAiD legislation and implementation of that understanding continues to evolve and mature. The recently published *Model Practice Standard For MAiD*[3] has contributed significantly to this understanding and in encouraging a standardized approach to assessment.

As an experienced MAiD practitioner, and as one who teaches others how to approach this practice, I would state as clearly as possible for your recognition that, in situations of MD-SUMC:

Someone in crisis is not eligible for MAiD
Someone who is newly diagnosed is not eligible for MAiD
Someone who hasn't had treatment is not eligible for MAiD
Someone seeking MAiD due to socioeconomic vulnerabilities is not eligible
Someone who refuses all treatments with no rationale is not eligible
Someone for whom there are accessible and effective treatments is not eligible
Someone for whom the assessors cannot come to a decision about any or all of the eligibility criterion is not eligible

3. Psychiatrists may potentially play two different roles under the procedural safeguards for MAiD, and we have enough psychiatrists already involved to move forward.

Legislation requires two independent clinicians find a patient eligible before they can proceed[4]. For patients whose natural death is not reasonably foreseeable (MD-SUMC patients), a clinician with expertise in the condition causing the person's suffering must also be involved.

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[2] See examples under References

[3] See References

[4] See References

Psychiatrists may therefore potentially play two different roles under the procedural safeguards for MAiD. First, they may be assessors or providers of MAiD, although few will be required for this role. Second, they may be consulted as a clinician with expertise in the condition causing the person's suffering.

Psychiatrists are already being consulted as "clinicians with expertise" in many MAiD applications. This is because they (already) possess the skills and training to be considered experts in their field. They do not require extra training to fulfill this role now or going forward. Canada therefore has 5000 psychiatrists[5] who are already adequately trained (to continue) to fulfill this role of expertise in MD-SUMC situations.

100 psychiatrist have already registered their interest in being involved in MD-SUMC. This represents ~2% of all psychiatrists in Canada. The 4th annual report on MAiD in Canada noted there were 1836 individual MAiD providers in 2022. This represents ~2% of the number of physicians in Canada[6]. If 2% of physicians can provide 13,000 MAiD procedures in one year, I suggest 2% of psychiatrists are sufficient to consult on what is rationally expected to be significantly fewer MD-SUMC cases.

Preparedness for MD-SUMC is clear.
Please do not let misinformation distract or cloud your deliberations on this point.

[5] See References

[6] See References

References

1. Readiness Activities Document - submitted to this Committee by the Canadian Association of MAID Assessors and Providers

2. Standards of Practice for MAiD - examples:

BC: https://www.cpsbc.ca/files/pdf/PSG-Medical-Assistance-in-Dying.pdf
AB: https://cpsa.ca/physicians/standards-of-practice/medical-assistance-in-dying/
SK: https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/POLICY%20-%20Medical%20Assistance%20in%20Dying.pdf
Man: https://cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Medical%20Assistance%20in%20Dying%20(MAID).pdf
ON: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying
QC: https://www.cmq.org/en/pratiquer-la-médecine/informations-clinique/soins-medicaux-de-fin-de-vie
NS: https://cpsns.ns.ca/resource/medical-assistance-in-dying/
NL: https://cpsnl.ca/wp-content/uploads/2023/09/Medical-Assistance-in-Dying-2023.pdf

3. Model Practice Standard for MAID
https://www.canada.ca/en/health-canada/services/publications/health-system-services/model-practice-standard-medical-assistance-dying.html

4. Procedural Safeguards
https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html

5. Number of Psychiatrists in Canada
https://www.cpa-apc.org/faq#:~:text=There%20are%20currently%20about%204%2C770,northern%20areas%2C%20even%20in%20Ontario.

6. CIHR data 2022 re # of physicians in Canada (96,020)
https://www.cihi.ca/en/a-profile-of-physicians-in-canada#:~:text=Supply%3A%20In%202022%2C%20there%20were,age%20of%20physicians%20was%2049