Written Brief Submitted to the Special Joint Committee on Medical Assistance in Dying (MAID)

Regarding Preparedness for MAID for Mental Disorders as a Sole Underlying Medical Condition (MD-SUMC)

Respectfully submitted on November 16, 2023 by

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I developed the MAID program for the University Health Network, was an expert witness for Lamb vs AGC, and have been the Capacity and Vulnerability Working Group Chair and Scientific Lead for CAMAP's Canadian MAID Curriculum. However, I am writing today as an individual whose opinions do not represent any of the organizations with which I am affiliated.

As a MAID Provider and a Physician Scientist with expertise in both suicide prevention and MAID, I believe I have a uniquely informed perspective on balancing "the autonomy of persons who are eligible to receive medical assistance in dying" with "the protection of vulnerable persons from being induced to end their lives".

I have grave concerns about our preparedness to expand MAID to MD-SUMC. These concerns are not based on ideological opposition to MAID for mental disorders nor on the readiness of the healthcare system. I appreciate the one year delay the government invoked allowing for training of healthcare providers and establishing processes for MD-SUMC. I also recognize that the healthcare system may never fully meet the mental health care needs of the population. I accept that these are not reasons to deny capable, eligible patients with mental disorders access to MAID.

My primary concern is that non-binding MAID practice standards and training do not carry the weight of legal requirements and are ultimately limited by a lack of critical clinical safeguards to protect vulnerable persons in the Canadian MAID legislation. This has left Canada with the world's most rapid growth rate in MAID provisions, the highest regional rates of euthanasia, and increasing national and international scrutiny of its MAID practice. The current laws permit too much latitude based on practitioner's personal values. Currently, it is a legal fiction that determinations of the eligibility of MAID are based on objective clinical judgments. In fact, I regularly witness practitioner's values influencing the interpretation of the current MAID eligibility criteria and safeguards.

For example, I have seen a young patient who met legal eligibility criteria according to two independent MAID assessors, who interpreted "incurable" to mean "by any means acceptable to the patient". This person was refusing any attempt at treatment for a cancer that had a more than 70% chance of cure. I now view this as a case of iatrogenic MAID - a term that describes inadvertent harm to patients caused by medical care.

I have also seen a case of a young person with a life-long history of treatment-resistant depression and anorexia who was on a long wait list for experimental treatment of that condition. She was intending to apply for MAID once it was legalized - until she was diagnosed with cancer, refused cancer treatment, and was urgently referred to me for assessment of suicidality. She was an extraordinarily intelligent woman, who would have met our usual thresholds for capacity. However, in comparison to the lifelong stigma she had experienced in the mental health system, she felt that her distress was validated in the cancer mental health system, where she was seen immediately and offered a difficult-to-access new depression treatment - which she received

and fortunately was effective. This experience of validation led her to withdrew her intent to pursue MAID and she began cancer treatment. Before she was diagnosed with cancer, I have no doubt that this young woman would have been found eligible for MAID MD-SUMC, and it would have been another case of iatrogenic MAID.

It is standard in medicine to withdraw treatments from the market due to adverse events, and 72% of the time this is based on anecdotal reports. Medicine aims to avoid iatrogenicity. The MAID legislation only requires practitioners to ask ***can*** this person have MAID; it does not require practitioners to ask ***should*** this person medically have MAID. It is said that a good surgeon knows not only how to operate, but when not to cut. However, MAID is the only intervention in all of medicine in which clinical judgment of the medical appropriateness of a treatment is not required to be routinely applied. Requiring the exercise of professional clinical judgment in MAID would protect against individual value judgments of practitioners.

Based on variable MAID practice I have personally witnessed, I believe that the Canadian MAID laws should be amended in the following ways:

1. Section 241.2(1)(d) should be clarified so as to indicate whether social determinants, such as the inability to access mental health care, poverty, or inadequate shelter, qualify as external circumstances that compromise voluntariness.
2. Section 241.2(2)(a) should be amended to clarify whether the criterion of "incurable" is based on objective medical standards or on the subjective view of the person requesting MAiD.
3. Section 241.2(2)(b) should be amended to indicate that "irreversible decline in capability" must be demonstrated after there have been clinically sufficient attempts at treatment.
4. Section 241.2(2)(c) should be clarified as to whether suffering *indirectly* due to the medical condition or to an irreversible state of decline (e.g. housing insecurity because a medical condition prevents them from earning a higher income that would allow them to pay for an increase in their rent) consitutes eligibility for MAiD.
5. Section 241.2 (3.1)(h) should be amended to state that MAID practitioners must "have had a clinical discussion regarding MAID that includes helping the person understand the meaning of their MAID request and agree that MAID is the best intervention to relieve the person's suffering".
6. Under 241.2(3) safeguards, a clear temporal definition of a reasonably foreseeable natural death should be specified, to prevent persons with a long expected survival from bypassing Track 2 safeguards. A reasonably foreseeable natural death is a legal, not a clinical concept. Whether to draw the line for eligibility at a 5-year life expectancy in a 90-year-old or at a 15-year life expectancy in a 70-year-old should be a Canadian public policy decision rather than a MAID practitioner's personal value judgment.

I strongly believe Canada's international reputation and the safety of Canadians depends on these nuanced but important and clinically informed changes.