Briefing to the Standing Committee on Justice and Human Rights

Regarding Bill C-7

Harvey Max Chochinov OM OC MD PhD FRCPC FRSC FCAHS

I am submitting this brief with the ardent wish to inform your deliberations regarding Bill C-7. My decision to do so is not so much driven a belief that my personal opinion on these matters is of critical importance, but rather my assertion that the data I will review is important for you to consider. By way of background, I am a Distinguished Professor of Psychiatry and the University of Manitoba; a Senior Scientist at the Research Institute of Oncology and Hematology, CancerCare Manitoba; co-founder of the Canadian Virtual Hospice; former chair of the External Panel on Options for a Legislative Response to Carter v. Canada[1]; and a long time palliative care researcher who has published extensively on matters pertaining to emotional dimensions of palliative and end-of-life care.

Bill C-7 proposes a number of changes with respect to how Medical Assistance in Dying is being carried out.[2] The first change I will address is the elimination of any waiting period between the time a dying patient is approved for MAiD and the administration of a lethal agent to end the patient's life. Based on empirical data, failure to impose some period of time for patients to reflect on their decision and for clinicians to discern its stability is problematic. Our research group was one of the first to study will to live in the terminally ill and reported that will to live can be highly fluctuant over intervals as short

as 12 and 24 hours (see figure 1).[3] On average patients demonstrated a 30 to 40 percent fluctuation in will to live, measured on a 0-100 visual analogue scale, over 12 to 24 hours respectively, with some patients demonstrating extremely wide fluctuations with 12, 24 hours; and 7 to 30-day intervals.

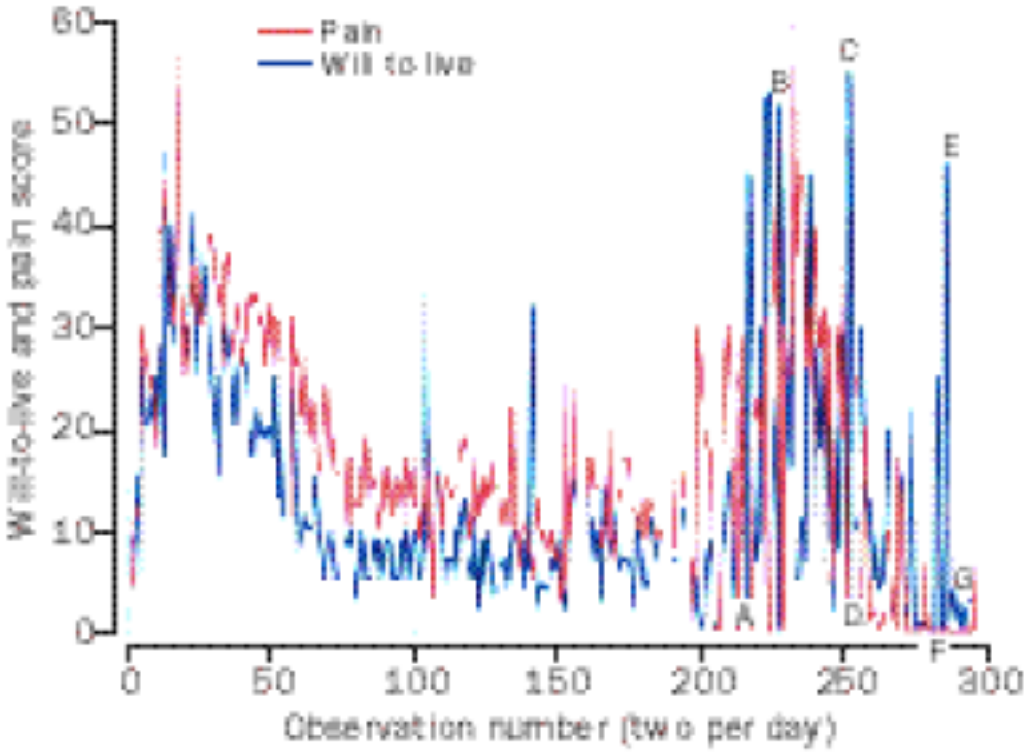
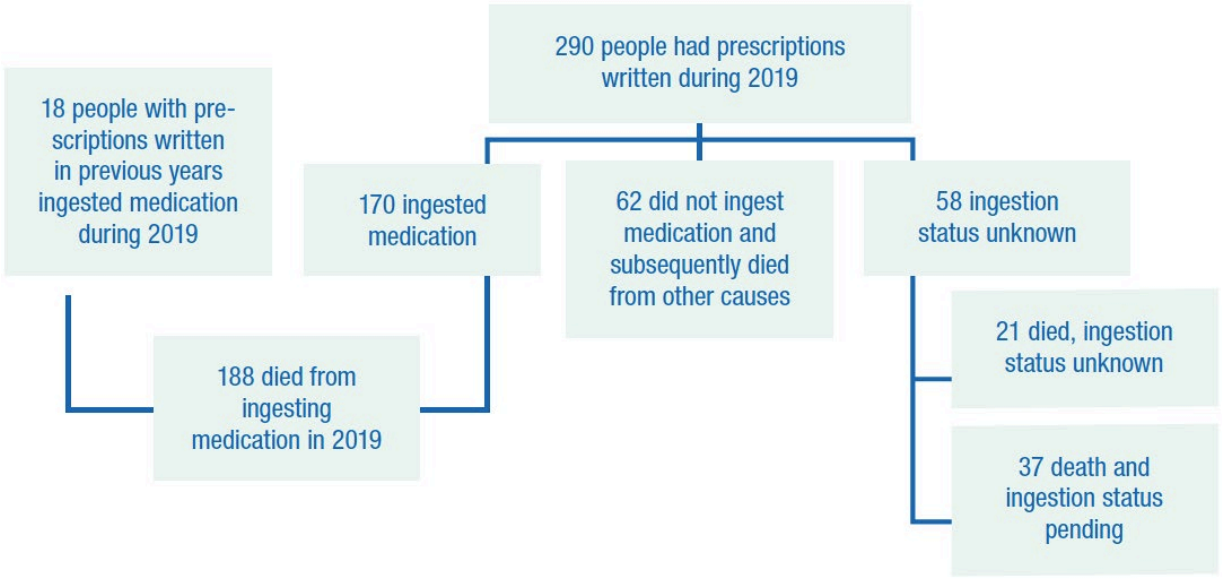


Figure 1: **Will-to-live and pain scores in an 82-year-old woman with colorectal cancer**
Maximum 12 h change=C–D; maximum 24 h change=E–F; maximum 7-day change=A–B; maximum 30-day change=B–G.

In our study of desire for death, we reported that of 4 of 6 patients who originally reported a desire for death relinquished their desire two weeks later.[4]

We also know that of all patients who are prescribed a lethal prescription under the Death with Dignity Act in Oregon, about 20 to 40% do not take a lethal overdose, preferring to let their underlying disease take its natural course (see figure 2).[5]

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2019, as of January 17, 2020



Bill C-7 also proposes to eliminate the requirement that a patient have a reasonably foreseeable death. In other words, patients will no longer necessarily be dying, but experience suffering on the basis of conditions whose life expectancy may be measured in years or even decades. For these patients, Bill C-7 recommends a 90-day assessment period. It is important to realize that the suicide rate in conditions such as spinal cord injury is 4.9 times higher than in the general population; head trauma is associated with twice the suicide risk as that of the general population; epilepsy, five times the suicide rate; and chronic pain by conservative estimates 3 times the suicide rate.[6] For these patients, suicidality is often less related to underlying physical limitations, but rather lack of social support, employment and relationship opportunities, poverty and feeling a

burden to others. A study out of the Baltimore City Hospitals followed a group of 496 patients with traumatic brain injury, stroke, or spinal cord compression.[6] They reported that 36 or 7.3% had a suicidal plan or had attempted suicide. They discovered that these suicidal patients were 6.7 times more likely to have a depressive disorder and 2.5 times as likely to have a family psychiatric history than patients who were not suicidal (see table 1).

Table 1 **Logistic regression analyses of demographic variables only (model 1) and demographic and psychiatric variables (model 2) for suicidal patients**

	Model 1[a]		Model 2[b]	
	Odds Ratio	95% CI	Odds Ratio	95% CI
Age	0.985	0.964–1.007	0.998	0.974–1.023
Gender, male	1.181	0.540–2.585	1.133	0.457–2.808
Marital status, married	0.382*	0.151–0.970	0.496	0.184–1.336
Race, African American	0.770	0.358–1.656	0.782	0.343–1.781
Education	1.027	0.915–1.152	1.046	0.921–1.188
Family psychiatric history			1.166	0.483–2.813
Personal psychiatric history			2.495**	0.919–6.775
Personal history of alcohol abuse/dependence			2.229	0.760–6.539
Depressive disorders (major or minor depression)			6.702***	2.549–17.622
GAD			0.842	0.355–1.998

Note: CI confidence interval; GAD general anxiety disorder. [a] Logistic regression model containing demographic variables only. The two-log likelihood χ^2 for this model was 230.312 (df 5, P 0.058). [b] Logistic regression model containing demographic and psychiatric variables. The two–log likelihood χ^2 for this model was 190.836 (df 10, $P < 0.001$). *$P < 0.05$, **$P < 0.10$, ***$P < 0.01$

Twenty-two of these patients were seen for follow-up, 6 of whom who were not depressed and 16 who were. Amongst those not depressed, 5 out of 6 patients were no longer suicidal upon follow-up between 3 months, up to two years later. Eleven of the 16 patients improved their depression and were found no longer to be suicidal between 3 months to two years later (see table 2).

Table 2 **Follow-up outcomes of initially suicidal patients**

Case	Diagnosis	Initial In Hospital	3-Month Follow-up	6-Month Follow-up	9-Month Follow-up	12-Month Follow-up	24-Month Follow-up
1	Stroke	Major	N/A	Major Suicidal		N/A	Nondepressed Nonsuicidal
2	Stroke	Major	N/A	Nondepressed Nonsuicidal		N/A	N/A
3	Stroke	Major	N/A	N/A		Minor Nonsuicidal	N/A
4	Stroke	Major	N/A	N/A		N/A	Nondepressed Nonsuicidal
5	Stroke	Nondepressed	N/A	N/A		N/A	Nondepressed Non-suicidal
6	Stroke	Major	Minor Nonsuicidal	Major Nonsuicidal		Nondepressed Nonsuicidal	Nondepressed Nonsuicidal
7	Stroke	Major	Minor Nonsuicidal	N/A		N/A	N/A
8	Stroke	Major	Major Nonsuicidal	N/A		N/A	N/A
9	Stroke	Minor	Nondepressed Nonsuicidal	N/A		Nondepressed Nonsuicidal	N/A
10	TBI	Major	N/A	Nondepressed Nonsuicidal	Minor Suicidal	Nondepressed Nonsuicidal	
11	TBI	Major	Nondepressed Nonsuicidal	Nondepressed Nonsuicidal	Nondepressed Nonsuicidal	Minor Nonsuicidal	
12	MI	Major	N/A	N/A	Nondepressed Nonsuicidal	N/A	
13	MI	Major	Major Suicidal	N/A	N/A	N/A	
14	MI	Nondepressed	N/A	Nondepressed Suicidal	N/A	N/A	
15	SCI	Major	Nondepressed Suicidal	Major Suicidal			
16	SCI	Nondepressed	Nondepressed Nonsuicidal	N/A			
17	SCI	Major	Major Nonsuicidal	Major Suicidal			
18	SCI	Major	Minor Suicidal	Nondepressed Suicidal			
19	SCI	Major	Nondepressed Nonsuicidal	N/A			
20	SCI	Nondepressed	Major Nonsuicidal	N/A			
21	SCI	Nondepressed	Minor Nonsuicidal	N/A			
22	SCI	Nondepressed	Nondepressed Nonsuicidal	Major Suicidal			

Note: Major = major depression; Minor = minor depression; N/A = not assessed

Bill C-7 also indicates that it will no longer be a requirement to reaffirm competency at the time of administration of MAiD. The closest equivalent in the literature is the euthanasia law in the Netherlands, which allows for an advanced directive for euthanasia for those who fear losing capacity. A Dutch study by Mette Rurup and colleagues surveyed

a group of 410 nursing home physicians, general practitioners and clinical specialists, 29% of whom had treated a patient with dementia who had an advance euthanasia directive.[7] Only three percent of the physicians had complied with the advanced euthanasia directive, while 44% had never done so but thought it conceivable they might in the future, and 54% had never done so and thought it inconceivable that the every would (see Table 3).

Table 3

. Experiences with and Actions Around Advance Euthanasia Directives of Demented Patients

Experience/Action	Nursing Home Physicians (n = 77)	General Practitioners (n = 125)	Clinical Specialists (n = 208)	Total* (N = 410)
	%			
I have treated one or more patients with dementia who had an advance euthanasia directive	66	28	23	29
I have treated one or more patients with dementia who had an advance euthanasia directive until their death in the previous 2 years	50	10	11	13
I have discussed whether to comply with the advance euthanasia directive of at least one of these patients	48	6	8	9
I have complied with the advance euthanasia directive of one or more demented patients	4	3	1	3
I have never complied with the advance euthanasia directive of a demented patient, but it is conceivable that I might	22	50	38	44
I have never complied with the advance euthanasia directive of a demented patient, and it is not conceivable that I would	74	47	61	54

* Percentages are weighted to make a representative estimate for all physicians in the Netherlands.

Compliance with the advance directive almost never took place because physicians either did not view it as a valid request or felt that euthanasia for a demented patient was unacceptable. When compliance with the advance directive was discussed, it was almost always raised by the patient's relative or representative or other physicians and nurses i.e. almost never by the patient. In 85% of instances, the patient's wishes could no longer be determined; in 72% of instances the relatives or representatives did not feel comfortable proceeding with euthanasia but settled on forgoing life-prolonging treatment, which was the position held by 90% of physicians.

Another Dutch paper by de Boer and colleagues examined compliance with advanced directives for euthanasia in dementia.[8] They surveyed the Dutch Association for Elderly Care Physicians, representing 90% of the total population of elderly care physicians. Of 434 physicians who completed the questionnaire, 110 indicated having treated a person with dementia who had an advance directive for euthanasia. Five of the 434 elderly care physicians reported that they had performed euthanasia on the person with dementia, but that *all patients were competent and able to express their wishes actively*. None reported having adhered to an advanced directive for euthanasia for an incompetent person with dementia. Only 5 patients initiated the discussion about the advance directive for euthanasia themselves; more often this was raised by the elder care physician, the relative or the resident's representative. In 85.5% of instances, the resident did not mention their personal advance directive for euthanasia or express their wishes regarding euthanasia; according to the physicians, most residents were incapable of doing so. The authors also reported that of those few who talked about their advance directive, about half changed their minds and the wishes of relatives often did not always match. In most cases, relatives did not want euthanasia but rather a limitation of life sustain treatments. The reasons for physician non-adherence to advance directive for euthanasia was that in 78% of cases, they were not able to determine the wishes of the person and in 97% of instances, the residents were not capable of judging their situation and making an adequate decision; non-adherence was also driven by the inability to determine the unbearableness of suffering of the person with dementia.

Finally, while Bill C-7 indicates that mental illness alone is not enough to quality for MAiD under Bill C-7, mental illness is often accompanied by medical comorbidities with functional impairments. The law does not require that a decline in capability be caused by the incurable condition, opening the door for medical assistance in dying for patients with mental illness experiencing various medical conditions. A study by Scott Kim and colleagues studied patients with psychiatric disorders who have received euthanasia or assisted suicide in the Netherlands between 2011 and 2014.[9] Of these 66 patients, nearly 60% had concurrent medical problems such as cancer, cardiac disease, stroke or neurological disorders. Psychiatric diagnoses included depression (55%) along with other conditions including psychosis, PTSD/anxiety, somatoform disorders, neurocognitive, eating disorders, personality disorders, as well as prolonged grief and autism (see Table 4).

Table 4. Psychiatric Conditions of 66 Patients Who Received Euthanasia or Assisted Suicide for Psychiatric Reasons

Psychiatric Condition[a]	No. (%)[b]
Depression, including depression with psychotic features	41 (35)
Anxiety other than PTSD, including generalized anxiety disorder, phobias, obsessive-compulsive disorder, panic disorder, social phobia	15 (13)
PTSD or posttraumatic residua	13 (11)
Psychotic disorders,[c] including schizophrenia, schizoaffective disorder, psychosis not otherwise specified, psychosis due to medical condition	9 (8)
Somatoform disorders, including pain disorders, somatization disorder, hypochondria	8 (7)
Bipolar depression	7 (6)
Substance abuse	6 (5)
Eating disorders	4 (3)
Neurocognitive impairment, including mental retardation, incipient dementia, brain tumor surgical sequelae, stroke	4 (3)
Prolonged grief	2 (2)
Autism spectrum	2 (2)
Other, including alexithymia, Cotard syndrome, dissociative disorder, factitious disorder, reactive attachment disorder, kleptomania	6 (5)

Conclusions: Bill C-7 introduces a number of changes to the current legislation regulating Medical Assistance in Dying. The data suggests caution regarding the following legislative amendments:

1. Elimination of the 10-day waiting period: The data indicates that the wish to die and desire for death in the context of terminal illness can fluctuate widely over time. Hence, some period for reflection would seem prudent.
2. Institute a 90-day assessment period for patients whose death is not reasonably foreseeable: The wish to die amongst patients suffering from non-imminently life-threatening conditions is not uncommon and can fluctuate over the course of months to years. When the determinants of a wish to die in patients living with these chronic conditions or disabilities are addressed, suicidality can abate.
3. Forgo reaffirming competency at the time of MAiD provision: The data strongly indicates that neither physicians nor relatives feel comfortable providing MAiD to patients who are unable to state their wishes and not able to convey that they are suffering intolerably.
4. Eliminating the provision of a reasonably foreseeable death: This opens the door for patients with various chronic medical conditions, including those with concurrent mental illness. Eliminating the *reasonably foreseeable death* clause fundamentally changes an act intended to assist those who are dying, to ending the lives of people living with various sources of physical and mental suffering. While death eliminates suffering and the sufferer, medicine must continue to

provide care that acknowledges, bears witness to, and mitigates the suffering of those who have lost their will to live.

References:

1. https://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/pad.pdf

2. https://openparliament.ca/bills/43-1/C-7/

3. Chochinov HM, Tataryn D, Clinch JJ, Dudgeon D. Will to live in the terminally ill. Lancet. 1999 Sep 4;354(9181):816-9. doi: 10.1016/S0140-6736(99)80011-7. PMID: 10485723.
4. Chochinov HM, Wilson KG, Enns M, Mowchun N, Lander S, Levitt M, Clinch JJ. Desire for death in the terminally ill. Am J Psychiatry. 1995 Aug;152(8):1185-91.
5. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf
6. Kishi Y, Robinson RG, Kosier JT. Suicidal ideation among patients with acute life-threatening physical illness: patients with stroke, traumatic brain injury, myocardial infarction, and spinal cord injury. Psychosomatics. 2001 Sep-Oct;42(5):382-90.
7. Rurup ML, Onwuteaka-Philipsen BD, van der Heide A, van der Wal G, van der Maas PJ. Physicians' experiences with demented patients with advance euthanasia directives in the Netherlands. J Am Geriatr Soc. 2005 Jul;53(7):1138-44.
8. de Boer ME, Dröes RM, Jonker C, Eefsting JA, Hertogh CM. Advance directives for euthanasia in dementia: how do they affect resident care in Dutch nursing homes? Experiences of physicians and relatives. J Am Geriatr Soc. 2011 Jun;59(6):989-96.
9. Kim SY, De Vries RG, Peteet JR. Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014. JAMA Psychiatry. 2016 Apr;73(4):362-8.