November 13, 2020

Via email: JUST@parl.gc.ca

Attn: House of Commons' Standing Committee on Justice and Human Rights

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

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 currently 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 also 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. I would like to be clear that my opinions in no way represent the opinions of the above organizations.

For the purposes of this brief, I will focus on the proposed exclusion of mental disorders. Section 2.1 of Bill C-7 proposes an exclusion of cases where mental disorders are the sole underlying condition leading to the request (MD-SUMC). The exclusion states: "For the purposes of Paragraph (2) (a), a mental illness is not considered to be an illness, disease, or disability."

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. 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 – in other words, with a high burden of disease. 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 that is part of the body, 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.

The exclusion lacks clarity, as well, in that illnesses such as Huntington's Disease and dementia are listed as mental disorders in the DSM-V (7). These illnesses are also considered to be physical and also carry with them a RFND; therefore, what will happen if mental disorders are excluded? What qualifies as a mental disorder under this exclusion?

Finally, the exclusion is arbitrary: under Bill C-7, individuals with comorbid mental and physical disorders would be eligible to access MAID, whereas those with mental disorders alone would not. This leads to arbitrariness in the implementation of the law, given that the existence of a "physical" condition creates a gateway to access MAID even when that physical condition is potentially easily treatable (for example, diabetes) or is chronic without a RFND (such as most cases of fibromyalgia) and the true reason for the request may actually be the mental disorder.

Moving on from the challenges in separating physical from mental disorders, I would like to address, briefly, 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. Factors such as 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 any individual 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 serve to protect vulnerable individuals.

2) Arguments about suicide contagion:

MAID and suicide are distinct phenomena, and arguments stating that MAID where there is no RFND, or MAID where mental disorder is the sole underlying condition, will cause suicide contagion risk conflating these phenomena. There is no good evidence to support this argument. An often-cited paper by Jones & Paton (8) is significantly flawed (9). Interestingly, data from the Organization for Economic Cooperation and Development (OECD) (10), 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 (11-12).

It goes without saying that suicide prevention should always be a top priority, and I would like to emphasise that the government should continue to bolster funding and efforts toward suicide prevention, and can do so 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) (7). 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 is highly stigmatizing, and 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 of this population. 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 has the potential to harbour cognitive distortions that have the potential to the decision and so to exclude only those with mental disorders on those grounds is not rational.

4. 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 patients have requested MAID on the grounds of a mental disorder or of a chronic illness without a RFND, the request has usually led to a thorough psychiatric assessment (the MAID assessment), as well as to access to new and additional resources and referrals. Colleagues with whom I collaborate have often made this same observation. I believe that the ability to make a MAID request could lead to improved access to resources, and it could act as a gateway to improved quality of medical care.

The existence of MAID for MD-SUMC can coexist with crucial efforts toward improving access to, and the quality of, mental health care in Canada. These efforts are by no means mutually exclusive.

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 often conduct multiple assessments over time, when the situation requires that, 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. 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,

Justine Dembo, MD, FRCPC

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