

Considerations with respect to the proposed changes to the Medical Assistance in Dying

Dear Committee Members,

My name is Philip Drijber. I am a practicing physician and have been doing so for almost 30 years. Among my qualifications, I am a fully certified member and Fellow of the Canadian College of Family Physicians, a palliative care physician, a medical director of a Long-Term Care home and an Associate member of the Canadian Board of Occupational Medicine. I also work as a Hospitalist (one providing care in hospitals). I work in a rural areas. I also have licenses in three provinces

I am writing you to voice my concerns about the extension of Medical Assistance in Dying (MAID) to those who do not have a reasonably foreseeable death or who see their medical condition as irremediable.

I understand this is a contentious topic. Many voices are asking to be heard. Some speak from their individual view and others, like myself, have a perspective as an observer and practitioner with these individuals

I read in the outline of how a briefing should be made, that references and scholarly articles. I understand that sentiment. Unfortunately, it is hard to design an experiment and judge outcomes when the methods eliminate half of those studied and there is not possibly of a “crossover” subset. When It comes to MAID, its finality for the subject makes it impossible to determine regret, or if other treatment regimens may have had a better outcome, due to the death of those choosing that option for disease treatment.

It is that very finality of the treatment option that makes this Bill so important and the fact that your committee must ensure that whatever changes made our in the best interests of the citizens of Canada as a whole and the individual wishing to access MAID.

Physicians have for years, have been guided by the motto of “Do no harm”. It would be a reasonable guideline for your committee as well. If we look back historically, Canada and Canadians, outlawed capital punishment because they felt its finality for the possibly wrongfully convicted, was a greater harm than the proposed good of that means of treating criminal behavior. Is it not equally important now to ensure any changes proposed do not affect the common good or cause harm to vulnerable, misinformed or suffering Canadians because we have what looks like an “easy” solution?

Since science will not allow us to create experiments to determine the right/wrong of this extension, then experience will have to be our guiding principle. Experience is a valid measure. It may not always be able to withstand strict scientific rigor, but it not negated by that. People experience pain and love. Neither can be proven by science, but both are known to be real.

This leads to my input for your consideration. My experience, and that of the whole field of medicine until recently, was that the desire to die was indicative of an underlying medical issue that needed to be resolved. It was a “Cry for help” that needed to be addressed and not one to be acquiesced. This observation and practice have been going on for centuries and needs not be made easily dismissed.

It has been my experience as a Palliative Care physician or Hospitalist in those patients requesting MAID, that if I asked the question what was motivating the request, I was able to address it and they changed their mind. The only time I was not able to address the concern was a case wherein the patient reported to me that his specialist told that patient to expect to die a painful, agonizing death and that there was nothing that could be done. This was incorrect information, but the fear of dying in pain made the patient choose MAID. Misinformation, like this, is one of the enemies in this discussion. Coercion, caused by misinformation, or coercion for an agenda of those close to the patient is also an enemy that needs to be addressed.

This law will extend the right to die to those that are disabled, but have no reasonably foreseeable death. My concern comes from my observations, as a physician, wherein the disabled are often made to feel systemically or specifically that their life is not worthy of living or that they are a burden to family or society or both. Ageism, the practice of devaluing the elderly simply because they are old, is one I deal with routinely in my roles as ER physician, hospitalist or long-term director. Families devalue their aging parents, or worse yet, wish them a hasty demise, and often for pecuniary reasons. Sadly, the medical system is no better at times and it not unusual for me to be asked by colleagues why I am seeking care for someone who is “so old”. Community funded support services are often lacking for the elderly or disabled. They must rely on family members who already stretched with other commitments. This creates a “perfect” environment wherein MAID looks like an alternative when the real alternative is to value the life of the disabled and provide compassionate adequately funded care in their community.

It is a fact that less than 30% of Ontario (my home province) has access to good Palliative care. It is equally lacking in the other provinces I work in although I do not know the exact numbers. It is this lack of Palliative care that has increased the demand for MAID among the dying. It is not because patients desire MAID, but because they wish to avoid suffering and have no access to good Palliative care. Extending MAID to the disabled will have the same effect. They may choose MAID not because they want it, but because they see no other option. Whether it is the coercion of societal messages of their being a burden on society, the wrongful societal message that their life is not worth living, the individual coercion of family or those with an agenda, does not really matter; what matters is that MAID should not be expanded until these systemic and specific influencers are addressed. If we cannot effectively address the drivers of hopelessness, systemic devaluation of people and create laws to protect vulnerable people from their own families, we should not be extending MAID for we will be knowingly creating a risk to life, freedom and right to be treated as an equal among Canadians that need not be created.

I understand there are advocates among the disabled that, as individuals, wish to have the right to decide when and how they die. They do not want anyone to limit their rights just because the law could potentially be abused. They feel individual freedom demands a right to access, especially when access already exists for others. In essence, this is what drove the Quebec decision, which in turn is driving the modification of the bill.

One of the problems with that line of thinking is that it fails to address the fact that society has the right to limit freedoms and does so everyday whether through traffic laws or criminal laws. As Oliver Holmes observed, individual freedoms do not include yelling “Fire” in a crowded theater. Society can put limits on individual freedoms for the better good of society. Although some of these suffering from disability may feel that they are not overtly suffering from external influences that make them feel their life is not

worth living, many do. I have seen it happen. Just as I alluded to earlier on, we as a nation choose to outlaw capital punishment to prevent the innocent from an irremediable punishment, so now we may need to choose to limit the rights of some individuals to protect others being coerced passively or actively into an irremediable choice.

In my role as an Occupational physician, I deal with disability. I understand how overwhelming and disheartening it can be. I see both physical and mental suffering. I see the losses and the impact they have on individuals self worth and their roles in their family and community. I am keenly aware of how difficult this can be. I am also aware that my role is to alleviate this as best I can. This can be through cure or through adaptation to a new normal. It always takes time. It is rarely an easy adjustment. It does happen though and people adapt and develop new ways to live their lives. In the process patients can feel the problem is irremediable, when all it takes is a bit more time, some patience and adaptive changes in their management. That which appears irremediable can be redeemable.

I have had similar observations for patients with mental health issues. Many feel there is no hope. They pine for death as an escape from the very real suffering they are experiencing. Some will suffer with mental health issues their entire life and experience many lows. They will also experience good times, however. The issue is that neither I nor they know when this will happen. But it does happen. It requires a lot of support from the community, family and the medical profession, proper medications, good lifestyle choices and counseling. All these can be costly and not all are easily available. This does not make the disease irremediable or incurable, just difficult to treat. We need as a society to value and fund the initiatives that make it possible to treat these diseases rather than write those off who are suffering from them as less valuable or a burden to society.

It can also not be ignored that there are financial implications for this decision. Sadly, the CMAJ published an article after MAID first became legal noted the expected savings in health care budgets. (CMAJ January 23, 2017 189 (3) E101-E105; DOI: <https://doi.org/10.1503/cmaj.160650>). It is likely to have similar savings for Social Services and Health Care if the disabled are expunged from the budget bottom line. Is that what we want? Is that another hidden agenda that the disabled must endure?

The lack of provision of Palliative care is a stark example of a driver of MAID among the dying. The Committee has a chance to make sure the lack of services to the disabled or disadvantaged does not create a driving force for MAID among those who are not dying, but whose hope for a better life is being replaced with an offer of an easy death. That is the low road. That is not kind. That is not Canadian. I trust that the Committee will choose wisely and do what is best for the disadvantaged.

I thank you for this opportunity to address you.

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