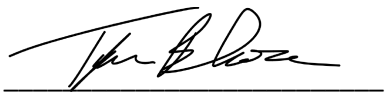
Evidence regarding MAiD and Suicide
Prepared by Tyler Black, MD, FRCPC

This evidence summary is intended to dispel myths about Medical Assistance in Dying and suicide. Unfortunately, these matters are often conflated due to the nature of the appearance of a "voluntary death," though one can quickly identify how both suicides and medically-assisted deaths are not truly voluntary due to circumstances that compel the decision-making. The wish to end irremediable suffering can be at the core of both, yet the rationality, processes, and impacts of the two are vastly different. I am submitting this evidence such that misinformation about suicide (unfortunately very common) is minimized as decisionmakers deliberate the impacts of changes to Medical Assistance in Dying.

About the Author: I am a child and adolescent psychiatrist from Vancouver, British Columbia. I am a Clinical Assistant Professor with the Department of Psychiatry. Clinically, I specialize in emergency psychiatry with 14 years of experience. My primary research interest is emergency psychiatry and suicidology. I teach suicide risk assessment at every level (from parent-based groups to specialists in psychiatry), and regularly publish, advocate, and interpret suicide research for media, public, policymakers, and medical professionals. I am the creator of the ASARI, a leading practice in Canada for the documentation of suicide risk assessment, as well as the co-creator of the HEARTSMAP, an emergency department psychosocial assessment tool.

Declaration of Conflicts: I have no financial conflicts to declare. In terms of possible philosophical conflicts of interest, as a physician I generally support Medical Assistance in Dying for people who have irremediable conditions of suffering.

I attest that the representation of the evidence below is my best attempt at synthesizing my clinical expertise and a review of the statistics regarding suicide and Medical Assistance in Dying. I am the sole author of this content.



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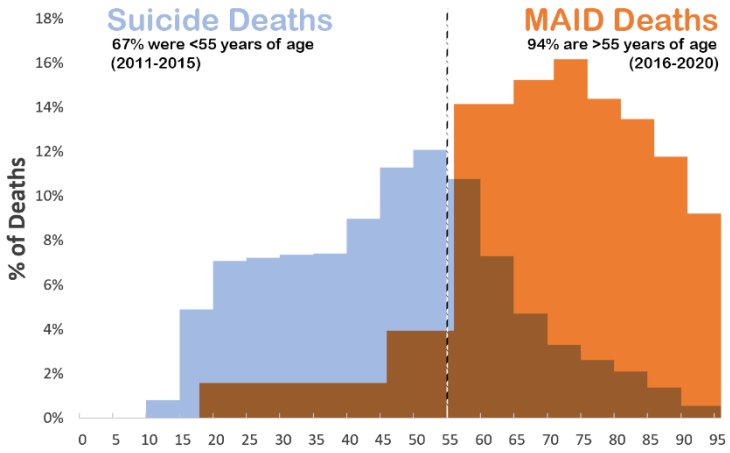
Myth #1 – MAiD and suicide are the same, and affect similar populations

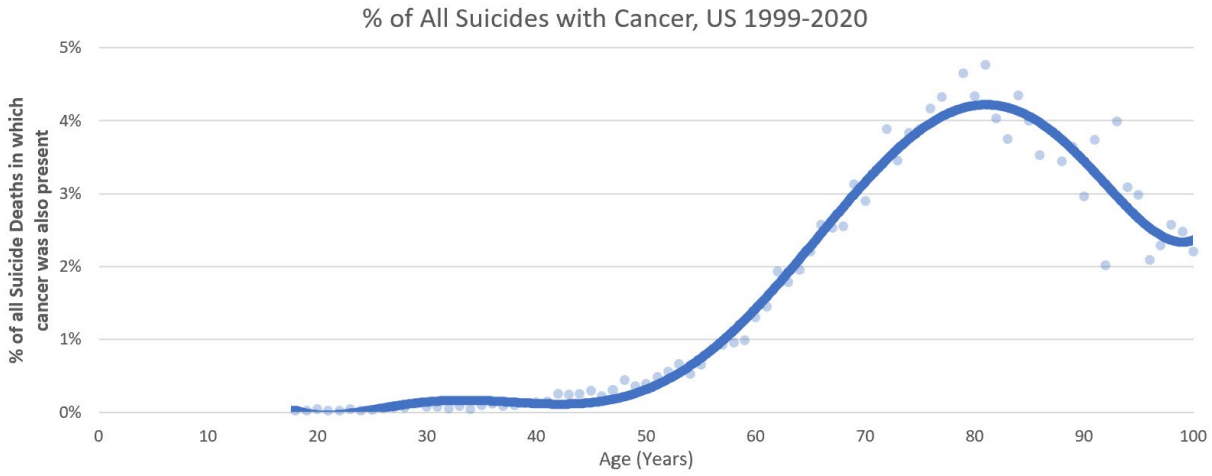
Evidence against this myth:

1) **The age distribution of MAiD deaths (2016-2020) is profoundly different** than the age distribution of suicide (2011-2015) prior to the enacting of MAiD legislation.



2) **The sex distribution of MAiD deaths (51.9% male, 48.1% female) is profoundly** different than the age distribution of suicide 2011-2015 (74.8% male, 25.2% female).

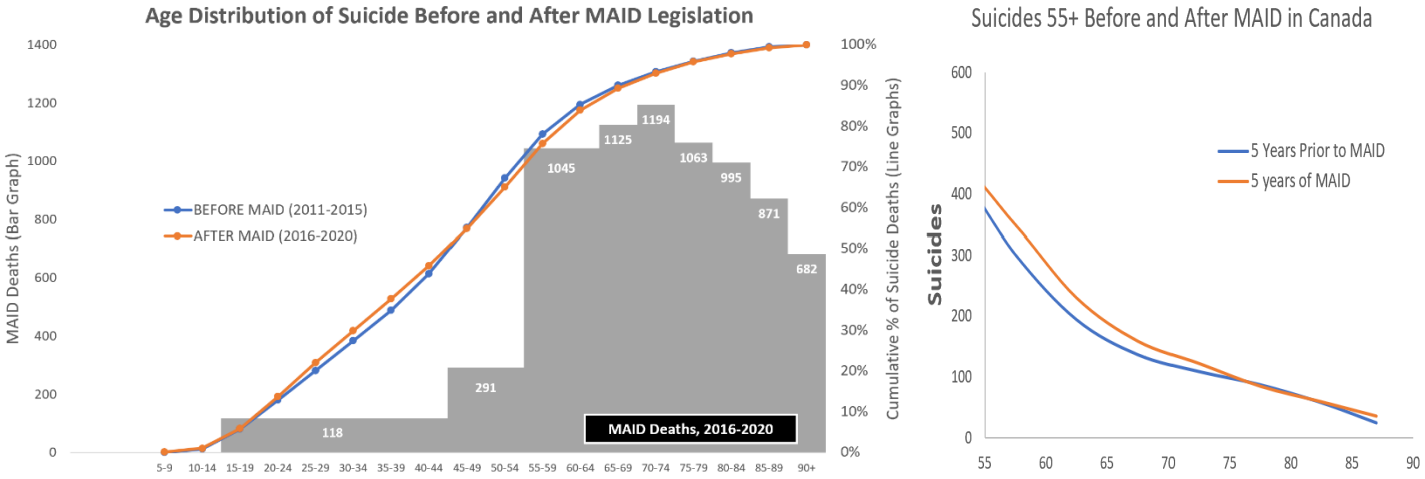
3) **About 70% of MAiD deaths in Canada involve people with malignant cancer diagnoses, where cancer is the primary medical contributor to the death.** This is in sharp contrast to suicide deaths, of which only a small fraction involve malignant cancer diagnoses. An analysis of CDC Data 1999-2020 in the United States reveals that 0.92% of all suicides (2.43% above age 55) occur in people with cancer severe enough to be recorded as a contributory cause of death.



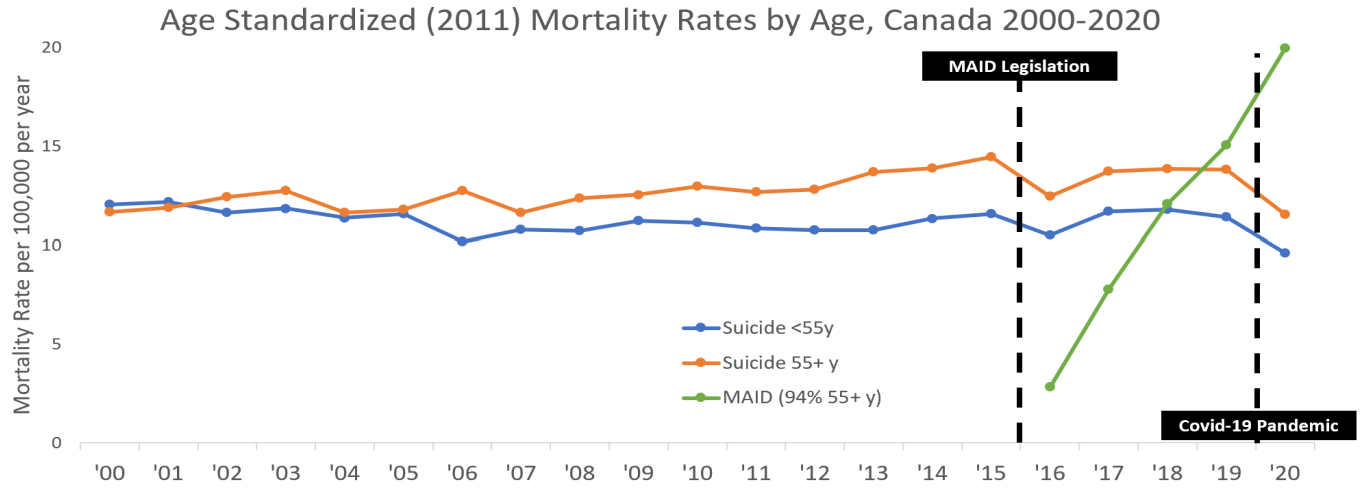
Myth #2 – MAiD Legislation has changed suicide deaths in Canada

Evidence against this myth:

1) **The age distribution of suicide deaths in Canada has not significantly changed despite MAiD being overwhelmingly provided to Canadians above 55 (94.4% of all MAiD deaths)**.
In the five years prior to MAiD legislation, there were a total of 6,730 deaths by suicide aged 55+. Between 2016-2020 there were 6,975 MAiD deaths aged 55+. Were MAiD deaths affecting the population of Canadians who die by suicide, we would see a profound effect on this graph.



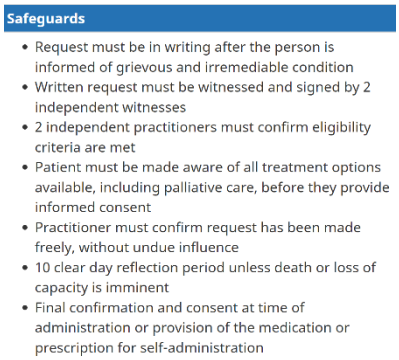
2) **The rates of suicide for Canadians older than 55 years old (94% of MAiD deaths) did not change significantly compared to the rates of suicide for people Canadians younger than 55 years old (6% of MAiD deaths) in the 5 years since MAiD legislation came into effect,** despite there being a sharp increase in MAiD deaths each year. The rate change for younger Canadians (<55 years) in the 5 years since MAiD legislation (-1.1%) is not significantly different from the rate change for older Canadians (55+ years) (-4.2%). There is no significant correlation with the increase in MAiD deaths and suicide rates in either group.



Myth #3 – MAiD motivations and suicide motivations are the same

Suicide has very different motivations from suicide:

1) **Anomic motivation** – this is the type of motivation that occurs when a stress (relationship, work, health, adverse event, finances; but NOT age) happens to someone and they have a *chaotic, uncontrolled response to that stress*. **By the nature of the safeguards as part of MAiD legislation, MAiD deaths are virtually never anomic**.



2) **Egoistic motivation** – this is the type of motivation that occurs when someone feels *disconnected from others and their life is meaningless*. Loneliness by itself may not be very important for death by suicide.

3) **Socioistic motivation** – this is the type of motivation that occurs where someone feels *connected to others and their death is meaningful.* This can include perceived burdensomeness, revenge against others, perceived correction of an injustice, acts of protest, etc.

4) **Fatalistic motivation** – this is the type of suicidal motivation that occurs when a stress (relationship, work, health, adverse event, finances; INCLUDING age) happens to someone and they have a *controlled, thought-out response to that stress*.

Suicides often have an anomic component, and many of the motivations may be irrational or distorted.

- 80% die on first attempt
- 50% have previous psychiatric illness
- acute stressors are found that were contributory
- in adults, relationship issues and new diagnoses of illness are the commonest stressors in suicide
- in youth, relationship issues, educational issues are the commonest stressors in suicide

MAiD deaths, by the safeguards and processes, are virtually *never anomic*. They fit to a very model of *rational* fatalistic, egoistic, and socioistic motivation, but **where a rational calculation of the motivation and likelihood of change** are applied. Due to the addition of anomic motivation, often **rationality is absent in** in suicide motivations, and distortions of egoistic, socioistic, and fatalistic motivations occur.

Nature of Suffering by those who received MAiD	Percentage
Loss of ability to engage in meaningful activities	84.9%
Loss of ability to perform activities of daily living	81.7%
Inadequate control of pain (or concern)	57.4%
Loss of dignity	53.9%
Inadequate control of symptoms other than pain (or concern)	50.6%
Perceived burden on family, friends or caregivers	35.9%
Loss of control of bodily functions	33.1%
Isolation or loneliness	18.6%
Emotional distress/anxiety/fear/existential suffering	5.6%

Myth #4 – Suicide and MAiD are experienced the same by families.

Evidence against this myth:

Suicide is devastating to families – rates of psychiatric admission, depression diagnosis, suicide attempt, and death by suicide are increased in family members who are in bereavement from a suicide in their life. The themes of grief after suicide include feelings of shame and stigmatization and need to conceal the details of the death.

In contrast, a meta-analysis of 10 studies in 2019 found **no increased incidence of poorer mental health or grief outcomes in family members of people who died by euthanasia/MAiD.**

A recent study in Quebec described no different outcomes in grief measures in family members who experienced a death due to MAiD or natural death with palliative care. That article has an excellent review of the evidence and I have summarized the various factors influencing a negative and positive experience with grief following MAiD.

Risk factors for worse grief outcomes	Protective factors for Better Grief Outcomes
Family disagreement	Family consensus
Value conflict	Being able to say goodbye
Burdens/Procedures in the Process	Feeling of control over suffering
Negative judgment, social stigma	Not having to witness a slow decline
Witnessing the death itself	Power to act: (planning, wishes, wills, etc)

Myth #5: Suicidal thinking is a "diagnostic criterion" for mental illness and does not occur outside of mental illness

Evidence against this myth

- The presence of suicidal thinking is neither sufficient nor necessary for the diagnosis mental illness. It is a criteria B symptom of major depressive episodes in the DSM-V-TR, and only part of one out of nine such symptoms for a major depressive illness.
    - **Criteria B.9:** Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- **18% of Youth** and **5% of Adults** think about suicide ("seriously consider suicide by survey) in any given year, and only a fraction (0.004% of Canadian Youth, 0.01% of Canadian Adults per year) die by suicide.
- Many people with and without mental illnesses think about, attempt, or die by suicide
    - ~40-50% of people who die by suicide have no mental illness at the time of their death
    - 28% of adults **with major depressive disorder** in the US **(4.6 million per year)** have suicidal thinking, and 2% of all American adults **without major depressive disorder (5.2 million per year)** have suicidal thinking

Myth #6 – When MAiD was introduced elsewhere, suicide rates increased, and suicide prevention measures suffered.

Evidence against this myth:

The following is a comparison between countries that enacted death with dignity legislation (Belgium and the Netherlands) and neighbouring countries that did not. Comparisons between countries have several challenges, but there is no empirical support for the notion that suicide rates increased or differed in MAiD-legislated countries versus those that didn't.

	Rate Change 5 years prior to 2002	Rate Change 5 years after 2002	Further change in rate after 2002
Belgium and the Netherlands	-1.4% per year	-2.9% per year	-1.5%
France and Germany	-1.9% per year	-3.0% per year	-1.1%

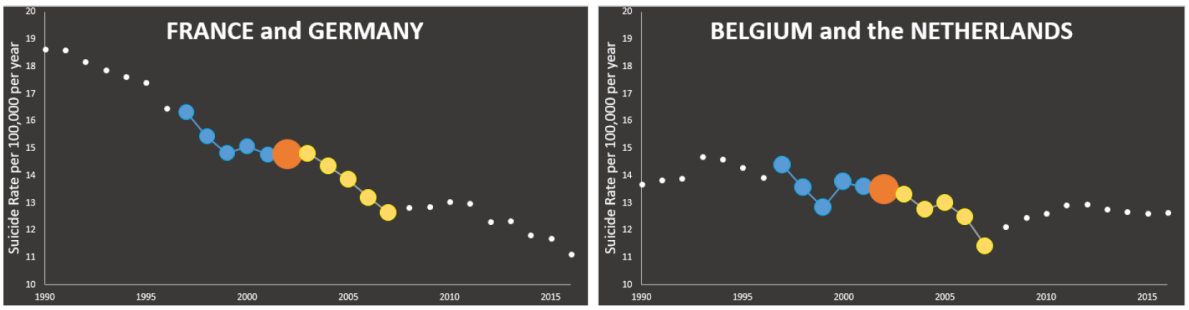


Figure 3 – Suicide Rates comparison years before and 5 years before (blue) and after (yellow) the period of passage of Euthanasia legislation in Belgium and the Netherlands, 2002 (orange)

Myth #7 – It is not possible to differentiate suicidal thinking that originates from mental illness and the desire for MAiD

Evidence against this myth:

The **assessment of capacity** is a psychiatric core competency and while it is never possible to fully know what someone is thinking if they wish to hide their true thinking, the process of capacity assessment involves:

1) A directed clinical interview
2) A review of medical records
3) The use of capacity assessment tools
4) Cognitive testing (not necessary but can be done)

A study of Dutch psychiatrists showed that psychiatrists generally concluded that "physicians distinguish three types of death wishes among patients suffering from psychiatric disorders: 'impulsive suicidality,' 'chronic suicidality,' and 'rational death wishes.'"

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