CMDA
CHRISTIAN MEDICAL AND DENTAL ASSOCIATION OF CANADA

**Special Joint Committee on Medical Assistance in Dying**

**Statutory Review of the Provisions of the Criminal Code Relating to Medical Assistance in Dying and their Application**

**Brief from the Christian Medical and Dental Association of Canada[1]**

In our submission, we express our concerns regarding access to palliative care and the proposed expansion of MAID to children, those whose primary diagnosis is mental health related, and to include the use of advance directives.

CHILDREN

When providing medical care to children and adolescents, a key concern is that capacity may not be present. Society recognizes the lack of neuroanatomical maturation in areas like voting and driving. The standard for capacity should be higher than usual when decisions are life altering or life threatening. Factors influencing capacity in minors include immature neurophysiological development, which results in biologically mediated difficulty with appreciating future consequences, psychological immaturity, ongoing evolution of identity, and vulnerability to peers and the media.[2] Previous experience demonstrates that the process of determining capacity in minors, such as children refusing life-saving chemotherapy, is a challenging and painful endeavor. Furthermore, we are concerned that the expansion of MAID to minors would jeopardize a population already known to have a high incidence of both suicidal ideation and peer pressure, and that effects might be particularly pronounced in subsets of young people with special vulnerabilities.[3]

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[1] CMDA Canada is an organization of Christian doctors, dentists, and students of those professions who seek to integrate their faith in practice.

[2] Casey BJ, Jones RM, Hare TA (2008). The adolescent brain. Ann N Y Acad Sci 1124: 111-126.
Johnson SB, Blum RW, Giedd JN (2009). Adolescent maturity and the brain: The promise and pitfalls of neuroscience research in adolescent health policy. J Adolesc Health. 45: 216-221.

[3] Among Canadians aged 15 to 34, suicide is the second leading cause of death. *Cf*. Navaneelan T (2017). Suicide rates: An overview. Statistics Canada. Accessible at www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm.
Gould M, Wallenstein S and Kleinman M (1990). Time-space clustering of teenage suicide. *Am J Epidemiol* 131: 71-78.
D'Augelli AR, Herschberger SL, Pilkington NW (2001). Suicidality patterns and sexual orientation-related factors among lesbian, gay, and bisexual youths. *Suicide Life-Threatening Beh* **31:** 250-265.
Kielland N and Simeone T (2014). Current issues in mental health in Canada: The mental health of First Nations and Inuit communities. Library of Parliament Research Publications. 2014-02-E. www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm

## PATIENTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS

Suicidal ideation is normally an indicator of serious mental illness.[4] Society has given physicians the legal right to admit someone to hospital against their will to be treated for suicidal ideation. Keeping a patient against their will, while extremely rare in other circumstances, is allowed in the case of the suicidal patient because their desire to harm themselves is evidence of their irrationality and incompetence.

A key determinant of eligibility for MAID is how the patient perceives their situation, but in a depressed individual, perception is skewed. It is also possible to be erroneously deemed competent while suffering from depression. Competence assessments are often suboptimal,[5] and unless the assessor has an appropriate level of suspicion, they may not recognize the cognitive distortion. Furthermore, depression often involves rigid and restricted thinking, such that an individual may insist on being euthanized, for lack of being able to conceive of another option.[6] Similar concerns exist for other psychiatric diagnoses as well.

In addition, prominent Canadian psychiatrists have maintained that it is impossible to prove that mental illness is irremediable.[7] Current Canadian legislation places no requirement on the patient to try a recommended course of treatment. Furthermore, the shortage of psychiatric services across Canada means that appropriate supports are often not available to patients. Finally, this change may undermine our societal emphasis against suicide.[8]

## ADVANCE DIRECTIVES

It is impossible to know how a patient will respond to the progression of their illness. Palliative care professionals observe patients' perceptions about dependence on others

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[4] One particularly high-risk population is First Nations communities. Some First Nations communities have suicide rates that are 800 times the national average. *Cf*. Kielland N and Simeone T (2014) (ibid.) Approval of MAID for people who have mental health challenges may be seen as a government endorsement of suicide. The lack of sufficient mental health services puts those communities at great risk.

[5] Appelbaum, P.S. 2007. Assessment of Patients' Competence to Consent to Treatment. *New England Journal of Medicine:*357:1834-1840. There is no standard assessment process or specific measures of competence.

[6] Clarke, D. M.(1999);*Journal of Medical Ethics* 25(6), 457-462.

[7] Maher, J. (2020, February 11). *Opinion | opinion | why legalizing medically assisted dying for people with mental illness is misguided | CBC news*. CBCnews. Retrieved May 9, 2022, from https://www.cbc.ca/news/opinion/opinion-assisted-dying-maid-legislation-mental-health-1.5452676

[8] This concern is emphasized in the following excerpt: "For many psychiatrists, however, assisting patients to die is incompatible with the way in which the therapeutic relationship between physician and patient should function to contain, understand, and manage despair and suicidality (Koerselmans, 1995, 2011). Indicating that they are willing to consider a patient's assisted suicide request after a therapeutic intervention were to fail would undermine the therapeutic process from the beginning."
Pols, H., Oak, S. 2013. Physician-assisted dying and psychiatry: Recent developments in the Netherlands. *International Journal of Law and Psychiatry*. 36:506-514 [p. 511].

becoming less negative as they become more dependent.[9] Moreover, dementia patients have stable quality of life ratings as their disease progresses. In the Netherlands, possessing an advance directive for euthanasia does not predict completion of euthanasia,[10] and such advance directives are rarely carried out for incompetent patients because of difficulty assessing the presence of voluntariness and unbearable suffering in this population.[11,12] Patients may resist euthanasia when they reach their previously defined conditions for it. Proxy ratings of quality of life (QOL) for dementia patients tend be worse than patients' own ratings,[9,13,14] and caregiver ratings of patient QOL have been associated with caregiver mood.[15] Moreover, the assessment of QOL in dementia in general is acknowledged in the literature to be problematic.[13,14,16] These factors render an autonomous decision about euthanasia impossible to achieve via advance directives, and introduce significant risk that factors other than the best interests of the patient will motivate decision-making where the potential for secondary gain exists.

## PALLIATIVE CARE

Palliative care enhances the quality of life for persons living with life-threatening illnesses and their families through assessment and treatment of symptoms, including physical, psychosocial and spiritual concerns. Palliative care supports a person living well before they die and must be kept distinct from MAID, which intentionally causes death.

Estimates of the number of people in Canada who have access to proper palliative care vary from 30 – 50%. We are concerned that the results reported in the annual Health

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[9] Canadian Society of Palliative Care Physicians. "Submission to Special Joint Committee on Physician-Assisted Dying." (January 27, 2016) Retrieved from http://www.cspcp.ca/wp-content/uploads/2014/10/CSPCP-Submission-to-the-Special-Joint-Committee-on-Physician-Assisted-Dying-National-Secretariat.pdf

[10] Bolt, E., Pasman, R., Deeg, D., Onwuteaka-Philipsen, B. 2016. From Advance Euthanasia Directive to Euthanasia: Stable Preference in Older People? *Journal of the American Geriatrics Society. 64(8):* 1628–1633.

[11] Kouwenhoven, P. et al. 2015. Opinions about euthanasia and advanced dementia: a qualitative study among Dutch physicians and members of the general public. *BMC Medical Ethics.* 16:7

[12] Hertogh, C., de Boer, M,, Droes, R., Eefsting, J. 2007. Would We Rather Lose Our Life Than Lose Our Self? Lessons From the Dutch Debate on Euthanasia for Patients With Dementia. *The American Journal of Bioethics*, 7(4): 48–56.

[13] Parker B, Petrou S, Underwood M, et al. Can care staff accurately assess health-related quality of life of care home residents? A secondary analysis of data from the OPERA trial. BMJ Open 2017;7:e012779. doi:10.1136/bmjopen-2016- 012779.

[14] Buckley et al, "Predictors of Quality of Life Ratings for Persons with Dementia Simultaneously Reported by Patients and their Caregivers: The Cache County (Utah) Study", *Int Psychogeriatr*. 2012 July ; 24(7): 1094–1102.

[15] Schiffczyk, C., et al. 2010. Generic quality of life assessment in dementia patients: a prospective cohort study. *BMC Neurology.* 10:48

[16] Hongisto et al. 2015. Self-Rated and Caregiver-Rated Quality of Life in Alzheimer Disease with a Focus on Evolving Patient Ability to Respond to Questionnaires: 5-Year Prospective ALSOVA Cohort Study. Am J Geriatr Psychiatry 23(12): 1280-1289.

Canada MAID report may lead to the false impression that palliative care is widely available for people considering MAID. These statistics, gathered by MAID providers, make no reference as to whether the palliative care received by those who had MAID was sufficiently comprehensive and in fact alleviated the symptoms of the patient. A Canadian study by Munro and colleagues in 2020 showed that 40% of patients had no palliative care involvement prior to requesting MAID.[17]

## CONCLUSION

Our experience of COVID-19 within health care has demonstrated the vulnerabilities of certain patients within the system. With reference to services and supports for the vulnerable people who might seek out MAID, it is clear that palliative care, mental health services, and supports for people with a disability are not consistently available across Canada. MAID has been made an essential service under the Canada Health Act. Why have the alternatives to MAID not been given the same designation? Is this the time to be expanding MAID before we have this serious problem resolved? Currently, lack of access to appropriate alternatives is not an obstacle to a request for MAID.[18] However, it could be the reason someone chooses MAID. In that case, our Association considers MAID under those circumstances to be a wrongful death, because we as a society can do better. Can a patient truly have autonomy when they have such extreme outside influence informing their decision-making? If we do not provide real options, how can we say it is a real choice? Are we really concerned about the welfare of patients, or simply balancing our budgets?

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[17] Munro C, Romanova A, Webber C, Kekewich M, Richard R, Tanuseputro P. Involvement of palliative care in patients requesting medical assistance in dying. Can Fam Physician. 2020 Nov;66(11):833-842.
[18] Favaro, A. (2022, April 30). *Woman with disabilities nears medically assisted death after futile bid for affordable housing*. CTVNews. Retrieved May 9, 2022, from https://www.ctvnews.ca/health/woman-with-disabilities-nears-medically-assisted-death-after-futile-bid-for-affordable-housing-1.5882202