Joint Submission to the Council of Canadian Academies’ Expert Panel on Medical Assistance in Dying

- on behalf of Canadian Physicians for Life, Canadian Federation of Catholic Physicians’ Societies and Christian Medical and Dental Society of Canada - October 6, 2017

Our main concern about the proposed expansion of the MAID criteria is the protection of vulnerable patients. In order for a patient to qualify for MAID, the current legislation requires that the patient’s death must be “reasonably foreseeable”. This clause is being litigated in British Columbia, and has already been redefined in a high profile case in Ontario. If this clause is struck down, reinterpreted, or if the MAID criteria are expanded, the main surviving test will be whether the patient has a “grievous and irremediable condition”. This is not a medical term, and does not have a precise definition. The Carter decision and subsequent legislation have defined irremediable as a condition that cannot be treated by any means that is acceptable to the patient. As the requirement for intolerable suffering is also subjective, physicians conducting assessments will be hard pressed to refuse MAID requests since there will no longer be objective benchmarks to measure criteria. The end result will be state sponsored suicide on demand. The expansion of the MAID criteria to include each of these groups of vulnerable patients needs to be considered in this context.

CHILDREN

When providing medical care to children and adolescents, a key concern is that capacity may not be present. According to the standards of Canadian medicine, acting on decisions made by a patient without capacity is not ethical conduct. Capacity is the ability to understand and appreciate the consequences of a decision. The standard for capacity is 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. Previous experience demonstrates that the process of determining capacity in minors (such as children refusing life-saving chemotherapy) is a high-resource and

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1 Canadian Physicians for Life, Canadian Federation of Catholic Physicians’ Societies, and Christian Medical and Dental Society of Canada represent 5,000 physicians in Canada. This response was drafted by physician members and friends of our organizations, who treat patients who are children, have psychiatric conditions, or who have an advance directive (vulnerable people).


It often requires expertise from clinical ethics, psychiatry, child protection, and the law. It is an emotionally charged issue for families, medical staff, and the general public. It is a high-stakes decision that is more serious than discontinuing treatment; as it involves actively taking a human life. In addition, previously identified general concerns about MAID, such as wrongful deaths in other permissive jurisdictions, are of greater concern in minors, given society's obligation to protect our most vulnerable. Overall, there is much less experience with MAID for minors on an international level, resulting in less reassurance regarding governments' ability to mediate potentially negative consequences. Furthermore, we are concerned that extension 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. Society recognizes the lack of neuroanatomical maturation in areas like voting and driving. Proponents for MAID for minors will need to answer why children are incapable of voting or driving, but yet are capable of choosing to die.

PATIENTS WITH A PRIMARY DIAGNOSIS OF MENTAL ILLNESS

Suicidal ideation is normally an indicator of serious mental illness. 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. Suicidal ideation and refusal of treatment are consequences of under-treated mental illness.

Depression afflicts those who have both long-term mental health diagnoses and the remainder of the population intermittently. Its effects are pervasive; it affects the brain, the mind and the way that people think and feel. Thinking patterns of depressed people are distorted; they are prone to pessimism, all or nothing thinking and often cannot see past the current moment. A key determinant of eligibility for MAID is how the patient perceives his/her situation, but in a depressed individual, perception is seen through a

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5 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.
dark lens. At the same time, it is possible to be erroneously deemed competent while suffering from depression. Patients can be rational about some aspects of their lives, and not others, so the request for MAID may appear to be a rational decision. Competence assessments are often suboptimal, and unless the assessor has an appropriate level of suspicion, he/she may not recognize the cognitive distortion. Furthermore, depression often involves rigid and restricted thinking, such that an individual who wants something other than what he/she is experiencing, may insist on being euthanized, for lack of being able to conceive of another option. Similar concerns exist for other psychiatric diagnoses as well.

Offering death for mental illness is unwise, since the most common reason for a request is clinical depression, which almost always resolves without medication within 6 months to two years. Other jurisdictions, such as Belgium, require the illness to be unresponsive to all possible treatments, while Canada currently does not require the patient to undertake any treatment.

When a patient is receiving mental health care, the greatest treatment their physician can provide is hope, caring for them, and imparting the message that life is worth living. How can the physician conduct an assessment to prevent suicide and provide care when that same assessment may also be used as a means to provide suicide? “Safeguards” will not protect people suffering solely from psychological illness because the tools mental health professionals use to protect and treat these individuals will be rendered ineffective in a permissive regime.

ADVANCE DIRECTIVES:

Advance directives pose additional problems. It is impossible to predict one’s experience of the illness trajectory. Palliative care professionals observe patients’ perceptions about dependence on others becoming less negative as they become more

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


9 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 (Koerselman, 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].
dependent. 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, 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. Patients may resist euthanasia when they reach their previously-defined conditions for it. In this case, would we respect the patient’s previously anticipated wish and ignore her current subjective experience because it is deemed to come from an incompetent mind? Would this not be an annihilation of the rights of the incompetent person? The implications of a scenario in which a proxy ultimately decides to proceed with the euthanasia of another person must be fully evaluated. Proxy ratings of quality of life (QOL) for dementia patients tend be worse than patients’ own ratings, and caregiver ratings of patient QOL have been associated with caregiver mood. Moreover, the assessment of QOL in dementia in general is acknowledged in the literature to be problematic. 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.

CONCLUSION

The expansion of the MAID mandate to include these vulnerable patients challenges the main philosophical underpinning of the legalization of euthanasia and assisted suicide – autonomy. Autonomy is only one of the four factors that make up modern medical

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ethics. Beneficence is another. If a patient tells their care team that they want to die what does it mean to do good for the patient? Does it mean to give them a lethal injection or to find an alternative? To simply let the patient decide begs the question. Various personal vulnerabilities and influences can make the patient unable to act in their own best interests. The current system of MAID assessment requires two physicians, neither of whom need to be intimately acquainted with the patient, to determine whether or not the patient is capable of consent and whether or not there is coercion. Coercion can be subtle and difficult to detect. Competency measures are very difficult to assess with each of these three groups of patients. It is not practically possible to expand the MAID mandate without a significant risk of wrongful death for some patients. In the end, it is not worth the risk.

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18 This was played out in Quebec when emergency physicians were faulted for not treating patients who came to their emergency department after having attempted suicide because they were “confused” about their duties. (Cf. Hamilton, G. “Some Quebec doctors let suicide victims die though treatment was available: college”, National Post, March 17, 2016. http://nationalpost.com/news/canada/some-quebec-doctors-let-suicide-victims-die-though-treatment-was-available-college) “Psychiatrists who fail to take reasonable care that their patients do not commit suicide, including by failing to order their involuntary hospitalization in order to prevent them committing suicide, can be liable for medical malpractice (negligence), unprofessional conduct (they lose their medical licenses), and even, in extreme cases, criminal negligence.” (Sommerville, M, Bird on an Ethics Wire [McGill-Queen’s University Press, 2015], pg. 131)
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