EDITORIAL

What Troubles me as a Psychiatrist about the Physician Assisted Suicide Debate in Canada

John Maher MD FRCPC
Editor-in-Chief

From my perspective as a psychiatrist, and in the context of the practice of psychiatry, there are a number of things that trouble me about the advent of MAID (Medical Assistance in Dying) in Canada. As my thinking and clinical experience coalesce around this profound change in our social fabric, I find that some conceptual confusion, artifice and diversionary rhetoric cloud some of the real issues.

Where is the money?

However well motivated (from an autonomy promotion, comfort provision, or legal perspective) the push for expansion of MAID to persons living with mental illness, the tragic and pervasive reality in the background is the lack of willingness by Canadian society and governments to put proper money into effective mental health treatment and services. The widespread lack of availability of timely and proven mental health care services is stigmatization, plain and simple. Look at cancer care or cardiac care and tell me that underfunding them (or not providing basic treatments in the first place) is acceptable.

And let's not be naïve about the reality that MAID will save health care dollars at the expense of its most vulnerable citizens.

How are people who already struggle with feeling like they are a burden on society or loved ones going to see this debate? As fostering their autonomy or giving them a push towards death?

"MAID" is a misleading term: this is about suicide not terminal illness

The term "MAID" is misleading when applied to persons whose sole underlying condition is a mental illness. They are not dying. Natural death is not "reasonably foreseeable". They are not "terminally ill" on any usual definition of terminal illness (e.g. the physical illness is causing death; death will occur in under six months). The proper terms when considering this population are "suicide", "assisted suicide", and "physician assisted suicide". The use of the term "MAID" represents conflation, obfuscation, and the application of a definition of dying that is too conceptually broad and indefensible. To say I am dying from the moment I am born is a poetically true and pragmatically meaningless assertion. To say I am dying because I have a serious mental illness with an attendant greater risk of dying by intentional suicide, or because of impaired judgment or cognition

or behaviour, is not logically tantamount to a claim I am physically dying and therefore may avail myself of, or deserve, or have a rights based claim to, any assistance a society might provide others who are actually terminally ill.

MAID is not a medical act in the context of mental illness

It concerns me that MAID for persons experiencing mental illness is claimed to be a shared medical decision and a subsequent medical act by a physician with a mentally ill patient. "Assistance" (the "A" in MAID) is an ambiguous term, but if it is a euphemism for "helping kill" the patient, then there is nothing in the long history of medical ethics and values that would construe that as a "medical act." If I am a doctor and help someone commit suicide, my involvement has not thereby made the suicide a "medical act". Many other non-physicians can proffer similar assistance.

There is a concerted attempt by some advocates to portray MAID as something very different than one more means of committing suicide (it is "supportive", "helps people on their difficult journey", "easier on the family", "less messy and traumatic"). However, easier suicide is still suicide. Anyone who has supported family members in the aftermath of suicide by a loved one with mental illness knows that the emotional horror, guilt, and anguish are not going to be assuaged by a better managed suicide. This backhanded attempt at validating or legitimizing suicide doesn't make sense in the mental health context (a context that works hard by virtue of history, values and mandate to prevent suicides). In response, some then try to shift the argument by saying that 'rational suicide' is inappropriately stigmatized, so we must call it something other than what it really is. This is circular and specious reasoning. On this view a doctor is really a sanitized version of a gun. But no matter how you parse it out, people living with mental illness can swallow their own suicide pills.

The real issue is whether society wants people living with mental illness to have easy or controlled access to effective suicide pills or devices, and under what circumstances. This is a social, moral, and existential question, not a medical question.

You are not entitled to assisted suicide because you refused mental health care

If I have a skin cancer that could be easily treated but I refuse treatment (as is my well established right in Canada) and the cancer progresses and I eventually become terminally ill, then I may have made myself eligible for MAID in the terminal stages. If a person has depression and refuses usual treatment options (CBT, medications, TMS, ECT) and then becomes actively suicidal, it is hard to see how this is conceptually analogous to the cancer example because the person is neither terminal nor without potentially effective treatment options right up to the moment of suicide, assisted or not. If you are a person with mental illness (or a duly appointed substitute decision maker) who refuses potentially effective treatments, then how do you have any defensible claim on society to provide assisted suicide?

Some people need special protection

Before the Quebec legislation came into effect, there was a decade of formal discussion, reflection, and consultation that ultimately led to the Quebec MAID legislation that specifically precluded people whose sole underlying condition is a mental illness. In the Carter decision the Supreme Court also excluded this population, as did the eventual federal legislation. When people argue that the reasons and conditions given in the court decision and legislation are subject to interpretation (e.g. When is death "reasonably foreseeable"? What is an "irremediable condition"?) and cannot preclude people with mental illness, it troubles me that the goal is to get this population included, rather than respecting the statute's apparent intent and spirit of protecting a vulnerable population. If persons with mental illness want, or have a rights based claim to, assisted suicide, then let's debate that for what it is and not muddy the intent and target of the existing legislation. The real questions are, "Do we want to help some people with mental illness commit suicide, and if so, who does the helping?" I will note that we already have suicide assistance groups with volunteers and effective means (the other end of midwifery); they just want the legal protection to do what they already do well.

Conscientious objection must be understood and respected

"In Québec's end-of-life legislation, physicians are allowed to refuse a request for medical aid in dying for personal reasons and are not required to make a direct referral. Instead, the physician must advise the authority specified in the legislation (e.g. hospital), and that authority will refer the patient. This allows Québec physicians to refuse to provide patients with assistance in dying based on conscientious grounds, while also permitting patients to obtain such care."(1)

Many physician colleagues outside of Quebec were surprised when their professional college announced as a fait accompli that even if they are conscientious objectors, they must directly refer a patient seeking assisted suicide to a colleague or organization that will help him or her commit suicide. There is a lack of appreciation for what true conscientious objection may mean for a given individual. If I was a Mennonite conscientious objector in wartime and I was assigned to a factory that builds bombs, even if I was not dropping the bombs, participating in the process might be unconscionable. An even more apropos analogy is if someone approached you to commit a murder on his behalf and you refused, and he then asked you to direct him to a good hitman instead, you would also adamantly decline all involvement. And so it goes that I might not wish to be part of any process or act of assisted suicide for persons with mental illness for many good ethical, spiritual, religious or cultural reasons. Being part of a pluralistic, secular society does not mean my college can compel me to directly or indirectly help someone commit suicide.

The only possible justification for a psychiatrist to be part of any process that might suborn suicide is to alert other physicians to (often missed) mental illness and decisional

incompetency, thereby safeguarding vulnerable patients whose vulnerability might otherwise be missed.

My role as a psychiatrist is to prevent suicide

That some psychiatrists in Europe are actually involved in not just the process but also the act of assisted suicide for persons with mental illness (injecting the lethal drugs themselves) is profoundly disturbing to me. My vocation as a psychiatrist entails the exercise of certain virtues and discipline specific expertise. A neurosurgeon removes brain tumors with aplomb. I help people make meaning of their suffering and find hope and purpose no matter what their life circumstances. Both specialists will fail from time to time, but our job and goal are clear. Just as the Pope should not perform abortions, and the Dalai Lama should not take up arms, a psychiatrist should not counsel or abet suicide, for in doing so I have misunderstood and betrayed my vocation and profession. A patient recently asked me for assisted suicide because God told her that since psychiatrists are saying it is acceptable, she needs no longer fear being consigned to hell. Validation of suicide or assisted suicide by psychiatrists is therapeutic and professional hypocrisy. When a colleague tells me I should help someone with a mental illness die because it is inhumane to let them live, I can't help but feel that it is the stopping trying that is inhumane. I have seen too many "hopeless cases" improve dramatically after many years of treatment to believe there is folly in my efforts; and if not me, then who keeps trying?

I will note that the American Psychiatric Association recently gave unanimous final approval to a policy statement declaring its ethical opposition to psychiatric participation in assisted suicide or euthanasia for a non-terminal patient. They said: *"The American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death."* Canada needs an equally clear statement.

This door should not be opened slowly: it should remain shut

When people tell me to stop arguing against assisted suicide for persons with mental illness because the legislative door has already been opened and precedent set, and they further tell me the time has come to regulate the process and not fight its emergence, I am not deterred. Speaking of safeguards, reflection periods, independent reviews, and competency assessments is downstream from where I am situated. Putting speed bumps in place does not magically make suicide right. On reflection there is something deeply, ethically wrong about this course we are exploring. Validating assisted suicide removes barriers, makes it the norm, and perversely makes caution appear obstructionist. Benjy Freedman, a Montreal bioethicist, may have been prescient in 1994 when he wrote (in response to the Sue Rodrigues case):

> "...arguments can be made with respect to two other conditions stated by the

> dissenting Justices: that the request for euthanasia or assisted suicide be firm and unwavering, and that it be provided by a fully informed person of undoubted competence. These conditions are not self-interpreting. They are, moreover, in large degree, social constructions, often understood as relative to accepted or expected choices. What the slippery slope reminds us is that social expectations change over time, under pressure of the previous choice. At present, for example, asking to be killed is an odd choice and might trigger searching questions about competence. Over time, however, this rigour might well give way. It is not hard to envision a time when quite the reverse obtains, when an ill person who fails to ask to be killed is judged to be "in denial" and for that reason in need of therapy." (2)

Endnotes:

(1) CMPA: Legal and regulatory proceedings; *Navigating legal or regulatory processes* Conscientious objection to medical assistance in dying: Protecting Charter rights Originally published June 2015 / Revised June 2016

(2) Freedman, Benjamin, The Rodriguez Case: Sticky Questions and Slippery Answers, McGill Law Journal 1994; 39:644-56

These opinions are entirely my own and do not represent the views of the Editorial Committee or Board of the JEMH.

John Maher MD FRCPC
e-mail: jmaher@cmhastarttalking.ca

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