MAID for Mental Illness: Myths & Facts

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Background: As a result of the 2019 Truchon decision in a lower court in Quebec, a revised Medical Assistance in Dying (MAID) law (Bill C-7) is now being considered by our federal parliament. The proposed legislation removes the "death being reasonably foreseeable" requirement and is opening the door for physician assisted suicide for people who are not terminally ill.

Some persons with mental illness, by virtue of brain disease that often includes symptoms of hopelessness and suicidal thinking, have long been recognized as potentially vulnerable to suicide inducement and, until now, have rightfully been excluded from eligibility for MAID. Suicide prevention is recognized as a critical mental health service necessary to preserve life. The Senate recently proposed an amendment that will eliminate this broad protection and allow state-sanctioned suicide for these vulnerable people, starting in 18 months.

Myth: The Senate supported an 18 month "sunset clause" because they wisely weighed all of the evidence they heard.
Fact: The preponderance of Senate Committee evidence did not support moving forward with MAID for mental illness (hence the Committee's very thoughtful report). Either there is adequate data to support determinations of irremediability or there is not. If it existed it would have been presented. It does not exist, so it could not be presented. Therefore, in ignoring the Committee report, the majority of members in the full Senate gave unjustified weight to supposition, fallacious reasoning, and/or a political agenda. Furthermore, they are trying to pre-empt the mandated (and COVID delayed) legislative review of Bill C-14; they did not weigh the clear recommendation of the Canadian Council of Academies that advised against proceeding with MAID for mental illness due to lack of data and the limits of clinical prognostication; they did not respect the informed pleas of myriad organizations representing the most vulnerable of citizens, or of the United Nations; and they are trying to bind parliament to a course of action of their own desire with no request for a reference to the Supreme Court.

New information or better reasoning will not miraculously appear in the next 18 months. The Senate has made us an outlier in the world. This is not about social progress, or recognition of a changing world and citizen values. The Senate is ignoring the evidence and sound reasoning put before it. Martin Luther King said his task was to help people see the injustice before their very eyes. I expected better from the senators. I needed better. I can tell you today the names of my patients who will die because of their actions….patients who are gradually healing but plan to stop trying.

Every Canadian citizen already has the right to kill him or herself. MAID for mental illness does not add any new legal liberty and there is no legal "right to death" in our charter.

Of the 100% of Canadians who attempt suicide, only 23% try again, and only 7% complete suicide. MAID for mental illness only serves to make suicide easier. Why does the Senate want suicide to be easier? The Senate has failed in its duty to protect.

Myth: Bill C-7 is not discriminatory.
Fact: Canadian disability organizations, mental health organizations, Indigenous organizations, and religious organizations all say Bill C-7 is absolutely discriminatory because it singles out vulnerable Canadians and offers them the inducement of physician assisted death without offering adequate disability supports or treatment to help them live full lives free of the suffering caused by poor health care, poverty, and stigma.

It singles out persons with disabilities and mental illness as a specific group of people who are not terminally ill but deserve access to MAID because they have enough suffering to warrant it. Sheer presumption and ignorance. Let's understand what discrimination is. It is pretending that all Canadians are equal in all ways. We must be equal before the law but we are all dealt different hands by fate and endure practical inequalities of many sorts. The obvious reality is that some of us face profound life challenges (disease, disability, stigma, discrimination, misfortune, poverty, isolation) and require laws that preserve our legal equality within the circumstances of our personal disadvantage. A law that offers death to one group and support and treatment to all others is the paradigm of discrimination.

Bill C-7 pretends to equality by singing a siren song of rights. It says all people with mental illness deserve respect, equal access to MAID, and freedom of choice, all the while ignoring, or even making a mockery of, the particular life realities of living with severe mental illness. This law proclaims that I should consider death instead of recovery. Vulnerable patients need protection from legislators and doctors who want to make it easier for them to die while simultaneously being denied access to universal mental health care. That is the true discrimination.

Myth: MAID is consistent with each doctor's professional obligation to practice according to established standards of care.
Fact: MAID for mental illness makes the doctor a consumer controlled tool of death rather than an expert supporting healing and reducing suffering. Of grave concern is the effort of some legislators to allow MAID for mental illness without any statutory requirement that all standard or reasonable treatments have been tried before the patient is killed. The law as it stands says it is completely up to the person to decide if they are suffering unbearably and they can refuse standard treatments that might help them heal or cope. To allow people to choose death over and above proffered treatments for their illness is an unprecedented undermining of basic medical ethics and a physician's duty to use their clinical skill and judgment to practice in accord with established standards of care. A doctor cannot support offering death when treatment is untried or incomplete.

Against such an unheard-of legislative backdrop, what safeguards can possibly work?

Myth: This is about ethics not data.
Fact: Evidence-based medicine relies on data. Applied medical ethics uses data to inform the ethical analysis. Unlike most physical diseases, we absolutely lack any prognostic data that can tell us which particular patients with mental illness are likely to get better and which aren't. There are so many treatment options in psychiatry (along with the passage of time, natural adaptation, learned coping, the alleviation of poverty and loneliness, and the comfort of meaningful relationships) that no studies have been designed that fully capture the complexity of individually unique healing trajectories. For example, having a baby and no longer being suicidal because of a newfound purpose in life are not the types of things commonly studied when looking at diseases. It doesn't mean we can't do some form of research, however imperfectly, but we haven't yet. Proceeding headlong into expanding MAID without such data to inform our social policy thinking is presumption and fantasy trumping data and reality.

Myth: Psychiatrists can predict which people will not recover from their mental illnesses.
Fact: Determining whether a particular psychiatric disease is irremediable is absolutely impossible. We can't know what is unknowable. People recover after 2 years and after 15 years. People can have improved symptom control and reduced suffering when they get skilled care and treatment. Shared suffering is reduced suffering. Inadequate care causes remediable illnesses to appear irremediable.

Myth: MAID doesn't make patients want suicide.
Fact: Clinical relationships are already being profoundly undermined. Some mental health patients are now saying, "Why try to recover when MAID is coming soon and I will be able to choose death?" Some patients keep asking for MAID while they are actually getting better but can't recognize it yet.

Most suicidal thinking is ambivalent. We must not have legislation that will lead people to death who otherwise would have healed or coped. Offering an easy path to suicide is an ethically indefensible inducement. You can't offer a sanitized gun in a white coat. Opportunity begets action.

Some say MAID is morally acceptable because the law and a doctor says it is...and it comes with all the idealized trappings of medical comfort along with the relief of guilt that often comes with suicide. And we know that there is a profound power imbalance that means the very offering of MAID by a doctor carries the message of hopelessness and the clear implication of a recommended course of action…choose death.

Myth: A psychiatrist killing patients does not violate medical professional ethics.
Fact: The World Medical Association condemns MAID as an extreme violation of medical ethics. The American Psychiatric Association unequivocally condemns MAID for mental illness as an extreme ethical violation. Surprisingly, the Canadian Psychiatric Association has not consulted its membership since 2016 and its current neutral position is that, "There are compelling legal, clinical, ethical, moral and philosophical questions that make this issue particularly challenging. At this time, the CPA has not taken a position on whether MAID should be available in situations

where mental illness is the sole underlying medical condition." Professional associations have a duty of moral leadership rooted in evidence and clinical expertise. Unfortunately, the CPA position of neutrality supports nothing and everything, and undermines its own credibility by bowing to politics over professional ethics and data.

Myth: MAID is not suicide.
Fact: The Canadian government defines suicide simply and clearly as, "the intentional action of ending one's life". MAID is suicide. The American Association of Suicidology does not support the claim that MAID is not suicide, except in the context of terminal illness. Those who claim suicide is impulsive and violent, while MAID is well thought out, peaceful, and dignified, are arbitrarily redefining what suicide is. Social engineering always begins with language engineering. Suicide is taking steps to cause your own death, whatever the steps. 75% of people plan their suicide, and many are completed with care and consideration of the impact on first responders and others. The characterization of all suicides as compelled, impulsive, and violent is factually wrong and perpetuates media stereotypes.

What is clear is that suicide is a raw agony for loved ones. The trappings of medical comfort and the mutual pretense of moral exoneration that the staging of the MAID event promises cannot diminish this sorrow. In fact, it can serve to inflame the wound through the betrayal by both medicine and state.

Myth: A doctor helping a patient complete suicide is not a moral issue in a secular and pluralistic society.
Fact: Continuing religious, social, and ethical reflection would not support this claim. Beliefs and prohibitions about suicide and doctors killing their patients have been held and argued for thousands of years but in our secularized and pluralistic society the media, politicians, and academia often relegate them to the sidelines in the forum of public debate. The disparagement of religious/faith-based perspectives is ironic given that 70% of Canadians report holding faith- or spiritual-based values. Many publicly mask what they privately hold.

All arguments for human dignity and mutual respect are primarily rooted in the religious narratives that shaped Canadian law and values. MAID advocates who dismiss objections to their position as being held by "religious people who can't tell me or society what to do" have profoundly misunderstood and devalued the breadth of serious ethical analysis that underpins traditional religious stances and attendant social structures.

Conscience rights are actually rooted in what informs our conscience: deep moral intuitions born of faith in something. Many good ethical arguments against physician assisted suicide are rooted not in faith-based or deontological claims but in relational, utilitarian, virtue, and professional ethics. There are many lenses through which we can find common ground and we must have a thoughtful and open discussion of what assisted suicide means for us as ethical (religious or non-religious) persons jointly forging caring societies.

Myth: There is good mental health care for all the sickest people in Canada.

Fact: Only 1 in 3 people get help. TMS for treatment-resistant depression is now 90% effective and only funded in 4 provinces. Wait times for all services can be years. Rural Canadians have poor access.

As we speak, 6000 of the sickest people in Ontario are waiting up to 5 years to get specialty psychiatric care. These are degenerative diseases. It is like being diagnosed with a growing brain tumor and having to wait years for chemo while you get sicker and sicker. This is systemic stigmatization and discrimination.

Death versus no treatment is not an autonomous choice.

Myth: Not allowing people with mental illness to access MAID is discriminatory.
Fact: This is a simplistic "equity of access" argument that claims unjustifiable priority over "equality of care" and "health rights"' and "right to life" arguments. On its own, it has face value and appeals to our sense of fairness. Understood properly, from the informed and wider vantage point of the real contexts of suffering, it is tragically narrow in focus. It is a defense of simplistic playground rules in a complex world of systemic ableism. It is like saying that everyone in the sandbox deserves toys to play with while ignoring the kids with amputations or in wheelchairs who can't get into the sandbox.

Myth: MAID for mental illness enhances personal autonomy.
Fact: All suicide is tragic. When considering suicide people weigh the various means at their disposal. For example, many choose to overdose; others may choose a method that they feel is most acceptable and accessible. Having MAID as an additional option does not actually enhance your autonomy because you can already complete your own suicide plan.

The MAID autonomy claim is analogous to this scenario: I can change the oil on my own car. I may have to check out a YouTube video and buy some tools, and I may get dirty, but as a decisionally capable person I can do it. If the government orders a mechanic to do it for me, my autonomy has not been enhanced. It has simply been made easier to get to the same endpoint. MAID advocates confuse autonomy with facilitation.

MAID advocates claim that not providing such facilitation "compels" people to kill themselves in violent and horrible ways. Who or what is doing the compelling? Many people do kill themselves in very thoughtful and peaceful ways and to claim otherwise is simply to betray ignorance of what actually goes on in the world.

From a suicide prevention perspective, suicide shouldn't be easy. We have two clear examples (gas in England, poison in Sri Lanka) that show unequivocally that ease of opportunity matters. We know this to be true for farmers with guns and doctors with pills. And soon, thanks to this law, patients with doctors.

Inducement, temptation, bolstering a power imbalance, false moral exoneration, and encouragement to die are not enhancements of autonomy.

Myth: People deserve death with dignity and MAID provides that.
Fact: This debate has distorted what dignity means. Dignity means deserving of honour or respect. What MAID advocates mean by loss of dignity is loss of control, loss of superficial appearance, and self-critical judgement. They have, tragically, subverted the most dignified acts of all: unfailing love and deep respect for each other in all life circumstances. Bathing my dying grandmother, whispered conversations on the threshold of separation, silent reflection and presence through a long night waiting for a last breath…these are the moments of greatest dignity.

Dignity is found within our relationships. It is about whether someone looks at you and treats you with respect rather than with subtle disdain or prejudice, or makes you feel like you are bothering them. Dignity is not about the means of death. Dying with dignity means dying in a milieu of care, love, kindness and respect. Anyone who says all of these things are not present in a natural death setting simply does not understand what dignity is.

Myth: People who have suffered a lot want MAID.
Fact: No, they want relief of suffering. But they have come to believe that nothing but death will work. Unfortunately, prolonged suffering severely constricts a person's decision horizon and they stop trying even when good options for healing or reduced suffering are presented to them. In animal research this is called, "learned hopelessness".

Ethicists speak of "first and second order desires". As an example, my first order desire may be to smoke the cigarette I have in my hand, but my second order desire…my more authentic desire…is to stop smoking because I want to preserve my health. With MAID, a person's first order desire is the immediate relief of suffering, but their second order desire is to heal, to live, and to have a meaningful life.

Myth: If a doctor says assisted suicide is morally acceptable then it is.
Fact: What makes any doctor more of a moral expert than your own conscience and learned values. Doctors have been elevated to new age priests but they only have the exact same claim to moral expertise as every other Canadian. A doctor, with all the attendant medical trappings and the halo of perceived goodness, provides false moral absolution and exoneration for a person choosing suicide and using the doctor as the sanitized gun. It is a dance of mutual pretense that does not withstand the scrutiny of ethical analysis. It is a suicide protocol masked by euphemism, false mercy, dissembling, willful casuistry, or naïve self-delusion about the righteousness of one's path and purpose.

Myth: Governments are not motivated to support MAID in order to save money.
Fact: If this is true, what was the purpose of the recent parliamentary cost analysis of implementing the new law? The government funded study said $150 million would be saved in the first year. If MAID is an essential "Charter right" that must be offered no matter what, why was cost considered? Afterall, it is patently obvious that killing terminally ill people, and disabled people, and mentally ill people, and socially disadvantaged people, sooner than otherwise, saves money. The social engineering agenda appears to be fostering an ethos where people nobly kill

themselves so that they are not a burden on others. Additionally, doctors killing such persons is framed as a great act of compassion rather the commodification of death in a secular age. This is ableism wearing a mask of virtuous hypocrisy.

Myth: MAID is a form of treatment for mental illness.
Fact: Killing someone is never medical treatment. It is a means of eliminating suffering while eliminating the sufferer as well.

Myth: Trying to protect people with mental illness from MAID is discriminating against them by saying they aren't capable of making their own treatment decisions.
Fact: Everyone agrees that most people living with mental illness are perfectly capable of making their own treatment decisions. Everyone agrees that there are some people who by virtue of illness (e.g. psychosis, depression induced suicidal thinking) can't make their own reasoned decisions. Where matters are complicated is with people who fall in the middle, people whose decisional capacity is uncertain and who therefore may not be able to provide fully informed consent to an offer of death. Research shows that if 100 psychiatrists assess a person with uncertain decisional capacity, 35 will have one opinion, and 65 will have another. Different psychiatrists have different skill sets and levels of experience. They also have biases like everyone else. As in the Benelux countries, if legalized here, there will be psychiatrists who become the super suicide helpers. Patients will doctor shop until dead.

Myth: We already assess decisional capacity for MAID for physical and mental illness together, so we must be able to do it for mental illness alone.
Fact: What this facile and specious claim tries to gloss over is that all current assessments in Canada are done only with people who are terminally ill. Terminal illness is, in fact, the current legislative condition that allows MAID to be offered. No such necessary condition exists, or has been formulated, for mental illness alone. If the necessary condition posited by MAID advocates for mental illness alone is a subjective claim of "unbearable suffering" then, in fact, the door will be opened to any Canadian seeking MAID for any reason (e.g. grief, tired of life, recent divorce) as long as they have some concomitant medical condition that they subjectively and unilaterally validate as distressing enough.

Myth: If MAID is legal it must be ethical.
Fact: Just because the law says something is legally allowed doesn't make it ethically acceptable. Laws have allowed slavery, apartheid, eugenics, forced sterilization, systemic racism, sexism, ableism, and ageism. This law joins a long parade.

Myth: MAID for terminal illness is the same as MAID for mental illness.
Fact: Terminal illness means sure death and no hope. Mental illness means no death and sustaining hope. Profoundly different states of being. Saying the two are the same for purposes of assisted death is twisting logic in the service of ideology.

With the "reasonably forseeable death" criterion removed in Bill C-7, the use of the "irremediability" criterion is being changed in practice from **definitely** irremediable to **possibly** irremediable. Is "possibly" good enough when what is at stake is not 6 months but 60 years?

Some people extrapolate from the "beautiful stories about warm goodbyes" with MAID for terminal illness to a claim that the same will hold true outside the terminal context. On the contrary, the Swiss, Belgian and Dutch experience shows the non-terminal context is fraught with distress (families don't support the death, families will not participate, families initiate legal action, families still have hope of recovery, families feel abandoned, family members are traumatized - including PTSD).

Myth: There is no meaningful distinction between physical and mental Illness when it comes to MAID.
Fact: There are brain diseases that are in the clearly defined domain of psychiatric disorders. Physiologically there is of course a continuum…we have one whole body. And suffering is suffering. However, diagnostically and categorically there is not one continuum. There are 3 treatment categories: physical illness, mental illness, and mixed illness.

Mixed illness includes dementias (e.g. Alzheimers) and certain neurological disorders (e.g Huntington's) that can meet criteria for terminal disorders.

Clear mental illness is distinguished by the brain diseases that cause psychiatric symptoms: suicidal thinking, abnormal mood, impaired cognition, psychosis, hopelessness…a very specific list of symptoms and symptom clusters. They are not terminal conditions.

Here is another way of telling the difference. With physical illnesses I know when treatment attempts are exhausted, and I make that determination in a medical milieu free of societal stigma. With mental illness:

- Treatment is commonly not available because of stigma
- Treatment is often not begun because of the impact of stigma on the person
- Treatment is often derailed because of the impact of stigma
- Treatment attempts are never exhausted because the treatment arsenal is substantial and healing can take years
- It is impossible to predict which patient may yet recover or have reduced suffering

Myth: Most psychiatrists support MAID for Mental Illness.
Fact: Psychiatrists are split over MAID for mental illness. We have little data to establish the degree of the split, but enough data to be certain there is a split. Anyone who claims there is an emerging consensus based on the silence of the majority is simply speculating. Psychiatrists have critical experience and expertise but haven't been asked any clear questions that reflect complex clinical realities or legislative options.

- In a 2016 survey, 500 of 5000 Canadian psychiatrists responded. 75% objected to MAID for mental illness. The Canadian Psychiatric Association has not consulted its membership since 2016. Its current neutral position is that, "There are compelling legal, clinical, ethical, moral and philosophical questions that make this issue particularly challenging. At this time, the CPA has not taken a position on whether MAiD should be available in situations where mental illness is the sole underlying medical condition." Of note, the American Psychiatric Association unequivocally condemns MAID for mental illness as an extreme ethical violation.
- In a recent Quebec survey, 263 of 1300 psychiatrists responded. 36% objected to MAID for mental illness in all circumstances, and 42% said we need at least ten years of treatment before we can consider that further treatment may not produce added benefit.
- Some psychiatrists say this split is about differences in personal values only. Others say it is about professional ethics which should apply to all psychiatrists. A very long list of medical professional associations around the world agree with the latter.
- Some say this is an ethical debate that should be decided by values. Others point out that values are informed by data and that we need to use our scientific and evidence-based methods, however imperfectly, to see what the data shows. Applied ethics uses data. The current data does not support determinations of “irremediability” for mental illnesses (we can’t predict who will or won’t get better over the long term). At this juncture, it seems all psychiatrists agree, “You can’t predict the course of illness for any individual”.
- A few psychiatrists have claimed, “MAID is not suicide”. Others say, “Outside of a terminal context, we can't practically or conceptually distinguish those seeking MAID for mental illness from those who are suicidal because of their mental illness". This latter position is supported by a large body of research and conceptual work from the Canadian and American suicidology associations, and myriad health professional associations.
- A few psychiatrists have said that if someone has subjectively suffered “long enough” we must respect their choice to die and help them to die. Different psychiatrists will have very broad interpretations of when patients have suffered 'enough' or had adequate treatment. Others say because it is impossible to predict when suffering may be relieved through treatment, or improved coping, that we have a professional duty to keep trying.

Highlighting these differences shows the split, but the analysis of the values, life stories, clinical experience and acumen, and variance of interpretation of the exact same data are what tell the story. It is complicated. What is not complicated is this. If MAID is allowed for mental illness, we know with 100% certainty that we will make fatal mistakes, and that we will take the lives of patients who would have gotten better...we just won't know which. The hundreds of people who will die by MAID who would have gotten better are not statistics. If it is your partner, or son, or daughter, do you want a psychiatrist who supports MAID and is legally sanctioned to kill?

Conclusion: We cannot know which mental illnesses are irremediable for any given patient. We simply do not have the data necessary to make definitive clinical determinations, despite what some may falsely claim.

Most Canadians are unaware of this artificially pressured legislative push. And only about 10% of psychiatrists have weighed in. Some of my psychiatrist colleagues are shocked to hear death could be offered without the requirement that at least standard treatments have been tried. They have absolutely no doubt that patients who would have gotten better will die if mental illness is not excluded in Bill C-7.

Canada offers MAID but not universal palliative care, disability supports, or mental health care. Do we congratulate ourselves for our compassion in giving people an easier way to die, while depriving them of the resources they need to live? How can Bill C-7 be justified while Canadians' health rights are ignored and unprotected? Is this what free choice looks like in Canada?

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