January 31, 2021

Brief on mental health as sole criterion for medical aid in dying (MAiD) (TM-SPMI)

Presented by a group of Quebec psychiatrists

Submitted to the Canadian Senate in the context of the study of Bill C-7

Dear Senators,

In this brief we wish to discuss the draft document prepared by six Quebec psychiatrists and two community partners and distributed by the ***Association des médecins psychiatres du Québec*** (Access to medical assistance in dying for persons with mental disorders. Discussion paper. November 2020. AMPQ). As this document was introduced during your debate on Bill C-7, which, according to some senators and experts, should also allow for MAID for mental disorders, we are aware that it could be used as an argument that the psychiatric community in Quebec is largely in favour of this expansion, which is not the case, and that the implementation of the practice in Quebec would be without problems and controversy, which is not true either.

We recognize the efforts of this committee to address a difficult subject, as well as the quality of the document presented.

However, it should be noted at the outset that this document represents the opinion of the committee, and should not be construed as representing the opinion of the majority of psychiatrists in Quebec. Reference is made in the document to a survey that is reported to have been answered by 21% of psychiatrists, but which has not been published. Therefore, no firm conclusion can be drawn from this survey.

We also note that this report was discussed at a forum organized by the Quebec Ministry of Health and Social Services on December 14, which was biased in favour of broadening access to medical aid in dying (generally known as euthanasia), and that a keynote lecture at the forum was presented by a Belgian euthanasia activist.

We present this paper as psychiatrists, and not as official representatives of the organisations with which we are affiliated. Not that we believe that our organisations would not have supported our position, but the short time frame did not allow us to consult the members of our respective organisations.

For the sake of brevity, we summarise our thoughts in the following points:

1. Mental disorders have essential characteristics that fundamentally differentiate them from physical illnesses.

a. Suicidal ideation is one of the main and intrinsic symptoms associated with the majority of severe psychiatric disorders. Moreover, it is not possible on a clinical basis to differentiate suicidal ideation from what would be considered a genuine request for euthanasia (medical aid in dying). The history of psychiatry reveals that whenever it was believed that symptoms or signs were specific to a disease (pathognomonic), this was disproven by subsequent rigorous studies. For example, some psychotic symptoms were thought to be specific to schizophrenia and not to bipolar disorder; this was later clearly disproven (we refer here to Schneiderian symptoms, for example). Only the patient's evolution can allow for a precise diagnosis.

b. The same applies to the desire to die: we can only know its true nature after observing its evolution. Unfortunately, if we later conclude that a patient's diagnosis was incorrect, we can no longer turn back if the patient has died by lethal injection.

c. All diseases are different and the same criteria cannot be applied to all of them. Psychiatric disorders are characterised by a long-term process in which the desire to live is at the forefront of our concerns. As demonstrated in rigorous studies, the desire to live or to die is a fluid, fluctuating process. The desire to commit suicide is an intrinsic part of the illness. And, as demonstrated in paraplegic patients, these fluctuations are sometimes measured in terms of years, not days or a few months as proposed in the bill. Patients end up adapting to their disability and wanting to live against all odds.

d. Moreover, prognostic uncertainty is always present in psychiatric disorders. It is not uncommon to observe a marked improvement following an encounter with a significant other, a new treatment trial, the presence of a dynamic care team in the patient's life, or the discovery of a new meaning in his or her life. This improvement is also often part of the natural course of the disease (e.g. schizophrenia, depression or severe personality disorder).

e. Irremediability of the disease is therefore not present in the case of psychiatric disorders, and consequently this criterion necessary for MAID is absent. For example, a study of 118 patients with depression described as "resistant to treatment" revealed that the majority (60.2%) achieved complete remission, and for 43.8% of the 118 patients the complete remission lasted at least 6 months (Fekadu, British J Psychiatry 2012(5) : 369 - 375).

f. Refusal of treatment is also an intrinsic component of mental disorders. There is no discipline in which court orders for treatment are so frequently obtained, to compel patients to receive treatment and medication against their will, for example; and patients are greatly improved and in some cases can return to a near-normal life. The duty to provide appropriate treatment is intrinsic to medical ethics; it is surprising that

certain authorities, including the *Collège des médecins du Québec*, ask us to suspend this duty when the patient asks to die. Indeed, it is the physician's duty to propose appropriate, proportionate treatment and not simply to rely on the patient's subjective opinion, which is certainly very important, but which is not the sole criterion for therapeutic decisions.

g. Thus, it is inconceivable to let the patient decide that a physician must take his or her life, when science confirms day after day that these people's suffering can be relieved and improved, and they can return to a gratifying life trajectory. A patient would not be allowed to undergo major surgery before trying other, less invasive treatments, such as medication or lifestyle improvements. For example, a patient with diabetes who requested an immediate pancreas transplant would obviously be refused this procedure until less aggressive interventions had been tried and failed.

h. Ambivalence towards treatment also remains a frequent and significant characteristic of mental disorders, and care teams have the task of accompanying the patient with sensitivity and respect along the therapeutic path.

i. In the context of treatment for mental disorders, the relationship between patient and health professionals, as well as the attitude of the health professionals, often plays a particularly significant role, and the duty of the psychiatrist and other health professionals is to try to instil hope, which is a very valuable therapeutic ingredient. The suggestion that the patient can obtain MAID instead of treatment, to improve his or her quality of life, is in this context contraindicated and incompatible with the clinical role which should not be to lead the patient down the corridor of despair.

2. In presentations in favour of, and advocating for, euthanasia for people with primary mental disorders, the example of severe obsessive-compulsive disorder that is resistant to all treatments is often given. This is an extremely rare situation, and the data does not in fact confirm this example. A study by Kim published in 2016 (JAMA Psychiatry 73(4):362- 368), and surprisingly not included in the AMPQ report, examined a series of 66 cases in the Netherlands who underwent euthanasia for primary reasons of mental disorder. Much more common and treatable disorders were represented: in 55% of the cases, depressive disorders were the primary psychiatric diagnosis. The majority of patients had personality disorders and were lonely and socially isolated. 70% of the cases were women, which is the opposite of what is observed for completed suicides; it can be suspected that this made suicide more "available" to women.

   Another study, among Belgian patients with mental disorders requesting euthanasia, demonstrates the excessive and idiosyncratic broadening of the concept of intolerable suffering. This study reveals that psychiatrists accepted that an important component of

the intolerable suffering eligible for euthanasia could stem from social, economic and even existential aspects, such as the loss of a loved one, a friend, a pet, financial problems or the feeling of being a burden on society (Verhofstadt, British J Psychiatry 2017 (211): 238-245).

3. We do not want to make inferences about the intentions of treating teams; these are often unconscious phenomena. However, it must be acknowledged that these patients generate a lot of powerlessness and frustration in the care teams. Being able to offer them medical aid in dying provides a sense of liberation and a tool to respond to their distress, and thus responds to our own powerlessness; it puts an end to a heavy burden for the patient, his or her loved ones and the treating team.

4. The document also suffers from an important gap: the term and concept of palliative care are completely excluded, and no palliative care experts were involved in drafting the document. In contrast to physical illnesses, we jump directly from active, curative treatment to euthanasia, without going through a palliative phase. In modern medicine, there is an important phase of palliative care which is primarily aimed at relieving suffering. Although this concept is only now emerging in psychiatry, it needs to be developed further. Palliative interventions need to be studied. Although it is difficult to name evidence-based interventions, as is also the case in physical palliative care, here we can think for example of different pharmacological interventions using psychodysleptics (e.g. ketamine and psilocybin), various neurostimulation interventions, and above all psychotherapeutic interventions such as those to accompany patients in suffering and help them to create meaning despite extremely adverse conditions, among others based on Victor Frankl's logotherapy. Proposing euthanasia for mentally ill patients is an unacceptable leap, completely ignoring an essential therapeutic phase, palliative care, in modern medicine.

5. Finally, several bioethics experts, including the Yale University bioethics group, conclude that it is clearly premature to open MAID to patients with mental disorders (Zhong, American J Bioethics 2019 (10), 61-63- See also for the Canadian perspective: Expert Advisory Group on Medical Assistance in Dying, Canada at a Crossroads: Recommendations on Medical Assistance in Dying and Persons with a Mental Disorder: An Evidence-Based Critique of the Halifax Group IRPP Report; Toronto: EAG, 2020).

Thus, favouring medical assistance in dying at this time for patients with mental disorders:

- Is inappropriate: the desire to die and refusal of care are an integral part of the illness and they improve with treatment of the mental disorder;

- Is dangerous: the desire to die fluctuates, corrects itself, improves…; the prognosis is uncertain and often favourable, and this desire declines over years rather than days or months;

- Disregards the doctor's ethical duty to offer appropriate and proportional care, because it resorts immediately to an ultimate solution based solely on the patient's wish;

- Disregards the fact that the majority of patients who avail themselves of it suffer from common and highly treatable mental disorders, contrary to what is supported by organisations campaigning for euthanasia;

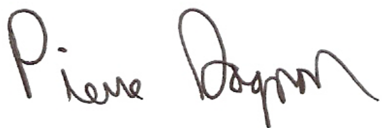
- Contributes to the elimination of patients who could represent a burden for families and care teams;

- Represents an inappropriate short-circuit in modern medicine without recourse to palliative care adapted to mental disorders.

We thank you for your attention to these considerations.

Sincerely,

Co-signatories:



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