

Submission to the Special Joint Committee on Medical Assistance in Dying

November 16, 2023

Dear Committee Members:

I am writing in my capacity as an adult psychiatrist working in hospital and community settings since 2004. I work with patients with severe and persistent mental illness, including patients with acute and chronic suicidality. In the course of my hospital work consulting to medical services, I have been a part of assessments for Medical Assistance in Dying (MAiD) for medically ill patients, including patients with psychiatric symptoms that could affect capacity. I have followed with interest the clinical ramifications of MAiD expansion, and do not consider myself a conscientious objector to MAiD.

Over the past several years, I have had several patients raise questions, concerns and interest in MAiD. As a clinician, I am committed to providing the best possible care to my patients and responding to their questions with integrity.

With respect to the expansion of MAiD to patients whose sole medical condition is mental illness (MAiD-MD SUMC), I have serious concerns about our readiness as a profession to safely enact this expansion in real-world clinical settings. These concerns center on a) the lack of a consistent definition of “irremediability” and b) the lack of safeguards against MAiD being chosen because of lack of access to a full spectrum of psychiatric care.

As a clinician, I have no way of predicting with accuracy which of my patients will, after decades of treatment, go on to make meaningful recovery, and which patients will continue to suffer grievously. It pains me deeply to think of my patients who have died by suicide, alone in their pain. At the same time, I have patients who have experienced persistent, intense suicidality, but after further treatment made significant recovery, and who now express relief at having been prevented from ending their lives. I have no way to tell the difference between these patients in advance, nor is there clear guidance on how then to presume to make such a judgement.

One of the interesting aspects of working with medical patients who request MAiD is examining and attempting to ameliorate the sources of their suffering. MAiD requests can lead to improved pain control, increased physical rehabilitation, and improved quality of life. In the case of MAiD for psychiatric illness, I am concerned that these conversations would not be as productive. Treatment of psychiatric illness often requires multiple treatment trials, including interventions that are not covered by provincial insurance, or are difficult to access without out of pocket payment. In Ontario, these include ketamine therapy for treatment-resistant Major Depressive Disorder, and Dialectical Behaviour Therapy for Borderline Personality Disorder: two conditions that are commonly associated with suicidality. People who cannot access these treatments would then be at risk of seeking MAiD due to income and access inequality, and no safeguards are in place to prevent this from occurring.

In watching the testimony of the November 7th meeting of this panel, I was struck by the evidence that there is a lack of resources in general for psychiatry, and the lack of readiness of the system as a whole, as acknowledged by Dr. Freeland. While it was emphasized that few patients would qualify for MAiD MD

SUMC, and that a small number of psychiatrists would choose to be involved with this process, the reality is that this expansion to MAiD would affect all psychiatrists and our relationship to patients who experience suicidality. The comparison of MAiD MD SUMC to novel therapeutics such as ketamine and psilocybin is patently absurd; these treatments were introduced within the existing framework of trialling new approaches to treating psychiatric illness, whereas MAiD MD SUMC represents a paradigm shift in how we respond to suicidality. The comparison is also ironic, given that ketamine and psilocybin treatments are not universally available, nor covered by provincial health insurance.

If in March 2024 MAiD MD-SUMC becomes an option, patients with psychiatric illness will begin asking for our assistance to end their lives. Our profession is not ready to respond to these requests in a manner that is safe and equitable. Though I as an individual would have the option to refer to colleagues who feel comfortable making such a determination, to me this would be an abandonment of my patients to a system that is moving faster than the evidence and reality of clinical care actually supports. I respectfully ask you not to put our profession and our patients in this untenable position.

Sincerely,

A handwritten signature in black ink, appearing to read 'L. Jamal', written in a cursive style.

Dr. Laila Jamal, MD, FRCPC