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Canadian Physicians for Life's members on

Physician-Assisted Suicide

Assisted dying law must protect the mentally ill

By Dr. Timothy Lau and Natasha Fernandes

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When the Carter ruling striking down Canada's laws prohibiting assisted suicide came down in February of last year it was made clear that safeguards could be instituted to protect the most vulnerable. Instead, recent recommendations by Parliament's Joint Special Committee on Physician Assisted Dying (PAD) extend euthanasia and assisted suicide to those with a mental illness and dementia. We will wait to see what the actual legislation will contain.

As psychiatrists, we are concerned that at a time when we should be discussing safeguards to ensure not one single Canadian is wrongfully killed, the Joint Special Committee focused on how to maximize access, regardless of competency. It is crucial for public safety that those physicians and institutions who can appreciate the serious flaws in such a plan should, at the very least, be protected and not forced to refer.

We have lost sight of the argument that was responsible for striking down our previous criminal laws. Sections 241(B) and 14 were deemed unconstitutional for the sole reason that they placed limitations on one's right to life; in so far as the person had to prematurely take their own life while they were able because no physician could perform that act at

a later date when they were physically incapable. That argument does not apply to the psychiatric population. Individuals with mental illness are not physically impaired and they are not terminally ill. In fact, PAD would actually intrude on their right to life by ending their lives prematurely, period.

Furthermore, patients with depression are inherently incapable of making a competent request for euthanasia. It is wrong to ignore the effect that depression can have on a person's cognition. We know depression can distort a patient's outlook on life. Suicidally depressed people are unable to realistically evaluate alternatives to suicide and the consequences of their actions, and so lack a central pillar of mental competency.

It is also important to reflect on the practical questions that psychiatrists offering PAD will inevitably face. It will be very likely that a psychiatrist will dissuade one patient from committing suicide in the morning and then see a patient in the afternoon whom they offer to assist in their death. What makes the first patient different from the second? Is the second patient harder to treat? Living a life less worthy? What measuring stick do we use to evaluate a "reasonable" request? What if the legislation fails to insist on obtaining information from friends and family? It is hard to know what is going on at home. Most concerning: Would it not make someone with



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depression even further depressed if their physician agreed that they should die? Would euthanasia generate its own demand?

Lastly, using advanced directives to euthanize those with dementia would be irresponsible. It is inconceivable to think of ending a person's life at a time when they are incompetent to make that request. We have no way of knowing if that individual has changed their mind and prefers life to death despite their dementia. No one, verbal or nonverbal, should lose the right to change their mind.

This is all to say that physicians' conscience rights not only should be, but must be, protected. The Canadian Medical Association president has reassured the Committee that protecting conscience rights will in no way impact access. It seems clear then, that a centralized registry or designated institutions where Canadians can go to seek out assistance must be supported.

Anything less would make Canada the first country to force physicians to refer for PAD and become a human rights violator in the process.

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