A Brief Submitted to the Joint Committee on Assisted Dying

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Thank you for this opportunity to present to your committee. By way of background, I am a Distinguished Professor of Psychiatry at the University of Manitoba; former chair of the Federal Government's External Panel on Options for a Legislative Response to Carter v. Canada; and a long-time palliative care researcher who has published extensively on psychological matters pertaining to palliative care.

If we are going to discuss safeguarding medical professionals, we need to articulate exactly what they need to be protected from. The context of a wish to die, whether it is a passive longing for life to be over sooner or an outright request for hastened death, is suffering; abject, soul crushing, suffering. Aside from how this affects the sufferer, for healthcare providers, it can elicit feelings of impotence and helplessness. This can lead to therapeutic nihilism and the impulse to abandon; with the rational being that, if suffering can't be fixed, it no longer resides within the purview of medicine. This kind of clinical withdrawal has been studied, and associated with heightened suicidality in patients who are denied follow-up or a reliable connection with their healthcare team.

Working in the context of suffering can also elicit a desire to fix or to rescue. Some of Canada's strongest MAiD proponents and providers have described their work as 'the most beautiful' they've ever done. I suspect these powerful feelings may represent collusion with hopelessness, wherein both parties share a mutual understanding that life for the patient has become futile; they feel aligned in having reached this joint conclusion; and MAiD appears to offer a quick and simple solution. Healthcare providers must

understand this nihilistic dynamic, pushing them towards a way to fix or eliminate suffering.

A wish to die is an expression of human suffering. Clinicians must learn to sit down and lean into discussions exploring the nature of patients' anguish, discerning their sources of distress, identifying potential solutions or mitigation strategies, recognizing that even the very acknowledgement of suffering—like feeling a burden to others, or no longer feeling like the person they once were—is a form of affirmation that can sustain patients' sense of worth and safeguard integrity of personhood.

With the advent of MAiD in Canada, too often, clinicians are inclined to interpret a 'wish to die' as an opening to evaluate eligibility for MAiD. This can be harmful for patients and healthcare providers. It leads both down a legalistic pathway, focused on whether specific criteria are being met, rather than entering a rich clinical encounter, foundational to palliative care and dignity conserving practices.

Last March I published an article on what I coined Intensive Caring. So far, it has been downloaded 10,000 time and describes ways for healthcare providers to address suffering, which includes not abandoning patients, investing in who they are as people, offering kindness, respect, and hope, affirming the ongoing worth of patients as human beings, while maintaining professional therapeutic humility. Healthcare providers must

become conversant with Intensive Caring, empowering them to be with patients who feel they no longer matter, or that their lives should be ended.

Our own research has shown that when healthcare providers become disengaged from the human side of medicine, and don't acknowledge patient personhood, they are less likely to experience job satisfaction. For some healthcare providers, the practice of MAiD takes them in a direction that feels antithetical to their professional calling. Feeling bound or pressured to make legalistic determinations about MAiD eligibility; feeling an obligation to refer when there is conscience objection; feeling that approaches embracing hope, healing and Intensive Caring are antithetical to a mindset that includes MAiD; can all lead to moral distress and a heightened risk of professional burnout.

In summary, the advent of MAiD will be accompanied by notable healthcare professional challenges that will require certain safeguards:

1) Physicians and health care workers must be free to not participate on many levels of this practice.
2) Insulating the practice of medicine from MAiD will safeguard patients, by allowing doctors and health care workers to focus on their suffering, recovery, and healing, without compromise.
3) Healthcare providers must never be obliged to raise the option of MAiD; an approach being advocated in Canada by MAiD proponents.

4) If assisted suicide is to reside within a medical model, it must be an exceptional procedure, separated and away from the heart medicine, and an option of last resort.
5) Conscience protection is critical; healthcare providers must not be forced, pressured, or coerced to act in ways that violate their beliefs, integrity, or standards of evidence-based practice.

Thank you for this opportunity; I am happy to answer any questions.