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My family medical practice cares for marginalized patients, including those living in poverty, refugees, men out of prison or facing criminal charges, the LGBTQ plus community, Indigenous persons, and those struggling with mental health/addictions/chronic pain & disabilities.

Too many in our country experience childhood racism, bullying and sexual abuse and these are not foreign to my own experience and to the lives of countless Canadians. I understand that the choice to die can easily be influenced by injustices life may have dealt us.

At prior committees I had raised concerns that inequalities and circumstances such as poverty (Ballard), trauma (Verhofstadt), lack of timely access to medical care (Janz and Herx) or lack of accompanying necessary supports, would *lead* to MAiD for those who would have recovered.

Known discriminatory factors against patients such as ageism, racism, or ableism can lead to harms caused by the health care team, or even lead to MAiD being raised as a treatment option to such a victim of discrimination.

I also warned that many injuries (Tchajkova et al.) and illnesses (Kishi et al.) are accompanied by transient depression and suicidal thinking. This suicidality ends with adaptation and support but takes on average two years. As well, studies show that after 2 years, disabled people rate their quality of life as the **same** as age matched healthy individuals. Offering MAiD

in a period of known suicidality would lead to premature deaths of people who would have recovered and been happy to be alive.

Now Bill C7 is legal and look at the result.

A man **had** a small stroke, affecting his balance and swallowing. The patient was depressed and isolated due to the Covid-19 outbreak on his ward. The stroke neurologist anticipated the man would be able to eat normally and regain most of his balance. He declined all therapy and psychiatry diagnosed him with an adjustment disorder, but they felt he would improve. However, he requested MAiD. Neither of his MAiD assessors had ANY expertise in stroke rehabilitation and recovery. In this acute phase, while struggling with his mood and isolation, and with no therapy to gauge his final level of function, he received MAiD. He had no terminal diagnoses, but because he was adapting to a thickened diet and so was temporarily slightly undernourished, they considered him track 1 eligible – with no required reflection period. No safeguards were technically broken and yet he died when acutely down and isolated and had not experienced living with maximal recovery from his stroke.

Mr. EN was a 71-year-old widower admitted to hospital for falls. During his admission he contracted an infectious diarrheal illness. He was openly humiliated by staff for the smell of his room. He developed new shortness of breath that was not comprehensively assessed. Without patient’s request, a hospital team member raised and recommended MAiD. The team said he had COPD and it held a terminal prognosis. The MAiD procedure was booked by the hospital team before he had even had his second assessment. Within 48 hours of his first assessment, he was dead. Post-mortem tests confirmed no significant COPD and his family doctor also said he didn’t have terminal COPD, but no one had contacted her for collateral history.

MAiD was raised to this patient. There is no safeguard in Bill C-7 legislation that forbids raising MAiD and the related amendment was voted down by the Senate. CAMAP has a document called Bringing up MAiD<sup>1</sup> and Stefanie Green and others have mentioned in the Special Joint Committee on Medical Assistance in Dying that MAiD should be raised as part of informed consent.

Was MAiD raised because his admission was longer than expected, because he was victim of ageism? Did he choose MAiD because his acute care team made him feel horrible? The The “In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care”<sup>2</sup> data report or the tragic story of Joyce Echaquan<sup>3</sup> demand we take these considerations seriously.

After CTV ran a W5 story<sup>4</sup> showing a gentleman’s MAiD provision, a patient let me know that the story was appealing, and MAiD would be good for her. My patient is in her early midlife, has a recent mild spinal cord injury. She hasn’t had time to adjust, receive any peer support or proper symptom control, nor reach maximal recovery, but she does now qualify for track 2 MAiD within 90 days. The legislation is built in a way that allows for her death before she has a chance to recover.

This case also shows that the government needs to consider how suicide research (see Niederkrotenthaler) shows that promotion of a suicidal message can lead to more people choosing suicide (Scutti).

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<sup>1</sup> See <https://camapcanada.ca/wp-content/uploads/2022/02/Bringing-up-MAiD.pdf>.

<sup>2</sup> See [https://engage.gov.bc.ca/app/uploads/sites/613/2021/02/In-Plain-Sight-Data-Report\\_Dec2020.pdf1\\_.pdf](https://engage.gov.bc.ca/app/uploads/sites/613/2021/02/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf).

<sup>3</sup> See <https://www.cbc.ca/news/canada/montreal/echaquan-coroner-report-health-care-system-racism-1.6199964>.

<sup>4</sup> See <https://www.ctvnews.ca/w5/a-rare-look-at-canada-s-growing-demand-for-medical-assistance-in-dying-1.5854612>.

This MAiD regime appears to be allowing a right to die **with government assistance for certain groups**. Inadequate safeguards suggest that this has been packaged and thinly veiled as a medical procedure. If this is not the case than your government must reconsider its MAiD legislation.

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