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Brief of the

Association for Reformed Political Action (ARPA) Canada

to

The House of Commons Standing Committee on Justice and Human Rights

regarding

Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*

November 12, 2020

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The main problem with Bill C-7

Medical assistance in dying (MAiD) is fundamentally different from any other medical service. Advising someone to obtain chemotherapy or pain medication is not a crime, but advising or encouraging someone to end their own life is still a crime. If MAiD were simply another health care service, it would not be before this Committee today because medical services are not regulated by the *Criminal Code*. Regulating the practice of medicine in general does not fall within Parliament's criminal law power. This Committee is wrestling with the question of when to permit some people to kill others who desire to die. That is why this is before Parliament.

Bill C-7 is flippant in its treatment of the deliberate termination of human lives. It seems primarily designed to make MAiD providers' jobs easier, rather than to ensure the full and equal protection in law of every member of the human family, regardless of disability, disease, or age, and to steer people away from assisted suicide and toward life-affirming treatments and supports as much as possible. Canada's current law, as amended by Bill C-14, is already being interpreted to allow doctors to euthanize patients who likely have a decade or more to live. The law already fails to prevent doctors from suggesting MAiD without being asked, which sends a powerful message to the sick and disabled that a doctor thinks their lives are not worth living. Bill C-7 fails to address the current problems under Bill C-14, as identified by the UN Special Rapporteur on the rights of persons with disabilities, among others, and even makes them worse.

Bill C-7 represents a radical change in Canada's law on assisted suicide / consensual homicide. It shifts from permitting MAiD in a limited end-of-life context, as an alternative to a drawn-out, difficult death, to offering it as a final escape from a difficult life or difficult period of life. Everyone will die, but only people with disabilities or chronic illness will be offered assisted death as a solution for suffering. The able-bodied who suffer will only be offered suicide prevention and various other supports. Society's message – particularly from our legal and medical systems – will be that some lives matter more than others. Parliament should abandon this bill and, instead, push back against the misguided *Truchon* decision be re-enacting an end-of-life criterion together with a clear statement of Parliament's objective in doing so, namely to prohibit euthanizing persons who are not dying as ethically and legally wrong.

Particular problems with Bill C-7

1. Discrimination against people with disabilities and chronical illness

Bill C-7's preamble notes that "Canada is a State Party to the United Nations Convention on the Rights of Persons with Disabilities," and that "Parliament affirms the inherent and equal value of every person's life and of taking a human-rights based approach to disability inclusion."

The UN Convention emphasizes that persons with disabilities are entitled to the same protections and benefits of the law *without distinction*.[1] The UN Convention contemplates special *accommodations and supports* as necessary to ensure persons with disabilities enjoy the same rights as others. Bill C-7, conversely, contemplates offering disabled people a "solution" to their

[1] See e.g. Sections 2 and 3 of the Preamble, and Articles 5, 10, 12, and 25.

suffering – deliberately induced death – that we would not offer to the suffering able-bodied. This is disability-based discrimination.

2. **A double standard on psychological suffering**

Psychological suffering alone should not make a person eligible for MAiD. Psychological suffering can never be considered definitively irremediable, as psychiatrist Dr. John Maher explains.[2] Bill C-7 clarifies that "mental illness" is not a "grievous and irremediable medical condition" and therefore cannot, on its own, make a person with mental illness eligible for MAiD. However, if a person has an illness, disease, or disability (s. 241.2(2)(a)) that causes her "psychological suffering" that is unbearable to her (subjective standard), that person will be eligible for MAiD under Bill C-7.

So, for example, this means that a person who is depressed after being paralyzed in a recent accident, but who is not suffering physical pain, will be eligible for MAiD, but a person who is depressed about losing a family member in an accident will not be eligible for MAiD. The latter person, instead of being offered MAiD, will only and continually be offered mental health support. We should offer mental health treatment and community supports to both.

3. **Euthanasia, quick and easy**

If Bill C-7 passes, it will be legally permissible for a person with a serious illness to walk into their doctor's office, have their doctor suggest MAiD as an option for them, have the doctor's secretary pop in to witness a written request for MAiD, and be killed as soon as a second opinion is acquired, possibly the same day. The doctor would have to mention other options, of course, but that is just a basic rule of informed consent. That is the fast and easy track.

The "slow track" is not much better. For those in the ambiguous category where natural death is not reasonably foreseeable, Bill C-7 says that other options must be discussed and consultations with service providers must be offered. Such basic steps should be required in "fast track" cases as well. Therefore, paras. 241.2(3.1)(g) and (h) of Bill C-7 should be added to the existing subsection 241.2(3) as well. Further, these provisions should be strengthened. It is not enough that a patient has been "offered consultations" with professionals who can help them. Before a person is euthanized, their doctor should be required to proactively facilitate meetings with other professionals who may be able to help their patient live well.

4. **Cutting the 10-day waiting period will cost lives**

As for the 10-day waiting period in the "fast track," it is irresponsible to eliminate it as Bill C-7 would. Dr. Madeline Li, expert witness in the *Lamb* case in B.C., developed and oversees the MAiD program at the University Health Network in Toronto. She notes in her expert report (attached as **Appendix A**) that psychological suffering is the main reason for assisted dying requests in all jurisdictions where it is legal (para. 6 on p. 5). Dr. Li describes the case of a woman who had bone cancer and a history of chronic depression (see paras. 20-21). This patient

[2] *CBC News*, Feb. 11, 2020, "Why legalizing medically assisted dying for people with mental illness is misguided."

was assessed by two "experienced MAiD providers" (not by her oncologist or psychiatrist) who approved her for MAiD. After her 10-day waiting period, she changed her mind and decided to pursue a palliative approach. Later, during another medical crisis, she requested MAiD again. Her MAiD physician decided that there were no concerns about her apparent ambivalence. But two days before her planned MAiD intervention, she changed her mind again and agreed to undertake new cancer therapies. This illustrates, Dr. Li says, the difficulty of accounting for the influence of anxiety or depression and other factors in a patient's request for MAiD. It also demonstrates the importance of waiting periods, and of offering all possible supports to a patient.

Air Canada and other airlines give you 24 hours to cancel your flight penalty-free. Bill C-7, however, would permit a person to request MAiD and be euthanized the same day or hour. It is not at all clear why the government thought deleting this safeguard was necessary.

5. Increasingly broad interpretations of *reasonably foreseeable natural death* means people with years to live will end up on the "fast track"

Bill C-14 (2016) made *reasonably foreseeable natural death* (RFND) an eligibility criterion for MAiD. As the Justice Department explained at that time, the bill was intended to limit MAiD to the end-of-life context, which is also why they chose the term "medical assistance in *dying*".

However, Bill C-14 noted that RFND did not require a specific prognosis as to how much time a patient likely had left to live, which some other countries or states that have legalized MAiD have included. The government likely avoided this for two reasons: 1. Political – to placate MPs who might think the bill was too restrictive, and 2. Legal – to guard the bill against court challenges by avoiding a prognosis-based eligibility criterion that a judge might consider arbitrary.

However, since Bill C-7 would expand MAiD to those without RFND, these reasons for not setting a specific time prognosis would be removed, or at least reduced in significance. If your natural death is not reasonably foreseeable, under Bill C-7 it would simply mean that you enjoy more safeguards, including the benefit of a 90-day waiting period – it would not mean you are ineligible.

One reason adding a time prognosis to Bill C-7 is so important is that MAiD providers quickly became quite liberal in their interpretation of the NFRD criterion, with some even boasting publicly that they have euthanized patients who likely had a decade or more to live.[3] Most MAiD deaths are caused by a small number of physicians who have no ethical objection to killing patients. It should not surprise us, then, that they will take a liberal approach to interpreting this law when it is plain that they can get away with it (we have not found any instances of prosecution).

Dr. Li writes in her expert report in the *Lamb* case (see paras. 72-74 on page 2 in **Appendix A**):

> *While there was more caution in using shorter prognoses for interpreting reasonably foreseeable natural death in the first year [after MAiD was legalized in 2016], following the CAMAP*

[3] Dr. Wiebe, who has euthanized several hundred people, says she goes by a roughly 10-year prognosis – a very loose standard from a scientific and medical perspective. See Joan Bryden, "Experts Concerned Ottawa has revived uncertainty over meaning of foreseeable death in assisted dying bill," *Globe and Mail*, March 3, 2020, online.

> *Reasonably Foreseeable Clinical Practice Guideline and the* A.B. v Canada *[re. elderly patient with advanced osteoarthritis, but not terminal] determination, some clinicians gained comfort with extending prognostic timeframes out to many years. […]*
>
> *The law as it stands contains enough flexibility in the interpretation of the end of life criteria that it is not a barrier for practitioners who are comfortable with expanding access to MAID.... Some have commented that the flexibility in interpreting what constitutes a reasonably foreseeable natural death render the criterion meaningless as a safeguard for vulnerable patients. Rather than removing this criterion, this safeguard could be strengthened by the addition of specific prognostic requirements.* [emphasis added]

If a time prognosis is not added, it would mean that a patient who has years – possibly more than a decade, depending on which doctor you ask – of life ahead of her, could nevertheless be sent down the "fast track" toward MAiD laid out in subsection 241.2(3) – as amended and weakened by Bill C-7 – rather than the "slow track" Bill C-7 would add in a new subsection 241.2(3.1). If you have years left ahead of you, then surely there is time to find you a health care provider with expertise in your condition (as s. 241.2(3.1)(e) requires), and to discuss available mental health and community services available to you (as s. 241.2(3.1)(g) and (h) require) before killing you. A sensible time prognosis might be RFND within 6 months.

6. The 90-day waiting period is not what you think

As for the 90-day waiting period, the Canadian Society of Palliative Care Physicians has noted that it is an insufficient amount of time to find satisfactory ways to manage a person's symptoms or to help them adjust to an illness or disability. We share this concern. We would also point out that the 90-day waiting period itself is ambiguous, given that it begins not on the day a written request is signed (as with the current 10-day waiting period), but on the day the doctor begins to assess a patient's eligibility, which could be months before a patient actually requests MAiD.

The problem is that we cannot know with certainty the day on which the assessment for eligibility began. Did it begin on the day that MAiD first came up in a conversation? Or the day the physician first began to consider whether his patient's condition was "grievous and irremediable"? Keep in mind that the written request for MAiD must be made *after* a medical practitioner has informed you that you have a grievous and irremediable condition. You may decide not to make a written request for MAiD until three months later, but the doctor may have begun (and largely completed) assessing your eligibility for MAiD three months earlier. This needs to be clarified in Bill C-7. The most straight-forward amendment would be to add a clarification that the 90-day waiting period begins the day the patient makes a written, signed, and witnessed request for MAiD.

7. The "waiver of final consent" provisions in Bill C-7 are reckless

Bill C-7 would permit (in s. 241.3(3.2)) a "written arrangement" granting medical practitioners the authority to unilaterally decide – with no second opinion and no witnesses – when a patient has lost capacity to give or withhold consent to medical care and to kill the patient at that time (provided capacity is lost *before* a date specified in the written arrangement). Unlike a written request for MAiD, which currently requires two witnesses (Bill C-7 would reduce that to one), a

subsequent "written arrangement" granting a medical practitioner a license to kill the patient requires no witnesses or second medical opinion.

To be clear, there is no requirement for any witnesses or second medical opinion:

1. when the "written arrangement" for waiver of final consent is formed;
2. when the practitioner decides to warn the patient of "risk of losing capacity" ((3.2)(a)(iii));
3. when the practitioner decides the patient has lost capacity ((3.2)(b)); or
4. when the practitioner kills the patient.

Subsections 241.3(3.2) – (3.4) contemplate euthanizing a person who, fearful of the possibility of losing capacity, entered a written arrangement with their doctor (without witnesses) wherein the doctor may unilaterally decide when the person has lost capacity. Further, these sections contemplate that a patient *might possibly* demonstrate refusal to be killed after seeming to have lost capacity – ss. (3.3) and (3.4) – but that the practitioner need not be try to give the patient any opportunity to do so. Best to kill them while they sleep, then, or simply sedate them first.

The preamble to Bill C-7 notes the "inherent risks and complexity" of allowing people to waive contemporaneous consent to being killed, yet it establishes *no safeguards or oversight for the use of this mechanism whatsoever*. The preamble also notes that Parliament's review of the MAiD laws scheduled for later this year "may include issues of advance requests" – yet Bill C-7 is charging ahead with a form of advance requests before Parliament's scheduled review.

8. **Cutting witness requirements puts convenience over safety and accountability**

Bill C-7 would apply a one-witness requirement whether one's natural death is reasonably foreseeable or not – meaning the issue is not the time it takes to find two witnesses. The value of two witnesses, of course, is that if anything suspicious emerges about the circumstances of a patient's MAiD request, the account of two witnesses can be compared. A person needs two witnesses to create a last will and testament. Surely it is not too much to ask to have two witnesses sign a request to have a medical practitioner euthanize someone.

Bill C-7 also lowers the bar for who qualifies as an *independent* witness. It allows medical practitioners or others who are paid to provide health care or personal care, including someone who provides care to the person who is requesting MAiD. The danger here is that medical personnel or support workers who approve of and grow accustomed to MAiD, or who work for a MAiD provider, may be routinely relied on to be the *sole witness*.

Bill C-14 (2016) did not prevent a MAiD provider's staff from being the witness, provided they are not "directly involved" in the patient's care. Therefore, we suggest the following addition to **s. 241.2(5)**: … **(e)** are supervised in their work by either medical practitioner involved in assessing the patient's eligibility for MAiD.

Leading patients toward MAiD

The preamble to Bill C-14 (2016) noted one of its goals as protecting vulnerable people from being "induced" to end their lives. The preamble of Bill C-7 (2020) says the same. Yet both bills do little to prevent such "inducement." Neither prohibits a medical practitioner from mentioning (and thus implicitly suggesting) MAiD to a patient without first being asked. In fact, neither bill clearly prohibits counselling or encouraging a person to seek a "medically assisted death." This should be prohibited generally, and medical personnel in particular should be prohibited from mentioning or discussing MAiD as an option for a patient without being explicitly asked by the patient.

MAiD providers typically say that their patients never feel induced or pressured to choose MAiD, and often feel pressure (especially from family members) not to choose MAiD. However, there are plenty of individual accounts of patients being offered MAiD without asking for it. Though these typically go unreported in the media, they deserve to be heard and taken seriously. Moreover, the problem was noted in an official UN Report. In the "End of Mission Statement" (April 12, 2019) of the UN Special Rapporteur on the Rights of Persons with Disabilities, there are many items requiring a government response. Canada has several major shortcomings when it comes to caring for persons with disabilities. With respect to MAiD, the Rapporteur says:

> *I am extremely concerned about the implementation of the legislation on medical assistance in dying from a disability perspective. I have been informed that there is no protocol in place to demonstrate that persons with disabilities have been provided with viable alternatives when eligible for assistive dying. I have further received worrisome claims about persons with disabilities in institutions being pressured to seek medical assistance in dying, and practitioners not formally reporting cases involving persons with disabilities. I urge the federal government to investigate these complaints and put into place adequate safeguards [...].*

This "Statement" was followed up by the UN Rapporteur's full Report on the visit to Canada (Dec. 19, 2019), which notes:

> *The recent judgment of the Superior Court of Quebec [Truchon] might put additional pressure on persons with disabilities who are in a vulnerable situation due to insufficient community support. As many persons with disabilities said during the visit, they are being offered the "choice" between a nursing home and medical assistance in dying.*

While it may appear to MAiD providers that their patients are not choosing a medically induced death because of outside pressure, in reality there are myriad subtle factors that can shape a person's desire to die. Dr. Madeline Li noted in her expert report in the *Lamb* case that psychological suffering is the main reason for assisted dying requests in all legal jurisdictions. People may feel a sense of hopelessness, or lack of purpose, or despair. They may feel that they are a burden on loved ones and society, or fear becoming a burden. They may imbibe the cultural narrative that a less independent life is one not worth living. All of these concerns can be addressed without recourse to ending the life of the patient.

Expanding MAiD is *not* constitutionally required

The *Carter* (2015 SCC 5) ruling was very limited in scope. The Court based its decision on the factual situation of Ms. Taylor, the plaintiff in *Carter* who had ALS, a fatal neurodegenerative disease. The Court refers to Ms. Taylor, "persons like her," and "persons in her position" throughout its judgement, as did the trial judge. The Court's *Charter* analysis is bookended by two key statements:

1. "For the reasons below, we conclude that the prohibition […] infringes the right to life, liberty, and security of Ms. Taylor and of persons in her position" (para 56).
2. After deciding the *Charter* issues and immediately following the declaration of the law's invalidity, the judgment states: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought" (para 127).

The lone judge who decided the *Truchon* case failed to appreciate this and failed to recognize Parliament's objectives in limiting MAiD to the end-of-life context. The ruling should have been appealed. Never before has Parliament amended the criminal law at the behest of a single, lower court judge. It is the responsibility of this Committee to listen to the concerns of all parties, including disability rights advocates, palliative care physicians, and others, to be clear about its objectives in limiting MAiD, and to enact more responsible, life-affirming policies.

Respectfully submitted,

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APPENDIX A

ARVAY FINLAY LLP

File No: 20001

6 September 2019

VIA EMAIL

Supreme Court of British Columbia
800 Smithe Street
Vancouver BC V6Z 2E1

Attention: Sue Smolen
Trial Coordinator

Dear Ms. Smolen:

Re: *Lamb and BCCLA. v. AGC*
SCBC Action No. S-165851, Vancouver Registry

I am counsel for the plaintiffs in the above-noted matter and Chief Justice Hinkson is both the case management and assigned trial judge. I am writing this letter with the consent of counsel for the defendant, Attorney General of Canada.

In the course of my review of the file it has become apparent to me that an adjournment of the trial is necessary or at least prudent.. This is because the plaintiff Ms. Julia Lamb is not at the present time prejudicially affected by the impugned provisions. This is revealed by the evidence of one of Canada's experts Dr. Madeline Li whose responding report is attached, but the key paragraphs of her report are as follows:

> ***Question 2: In your opinion, if Ms. Lamb requested a medically assisted death at a future date, would she meet the eligibility requirements of the existing medical assistance in dying laws? Why or why not?***
>
> 66. When Ms. Lamb clearly expresses an intent to receive MAID, either now or at a near future date, I believe she would meet all eligibility requirements of the existing MAID law, including all current criteria for having a grievous and irremediable medical condition, as detailed below.
>
> 67. Spinal Muscular Atrophy Type 2 is clearly a progressive, incurable condition.
>
> 68. As she is unable to walk, turn in bed, attend to her own activities of daily living, and she struggles with writing, swallowing, and breathing during sleep, she clearly meets threshold for being in an advanced state of irreversible decline in capability.

69. Intolerable suffering is an entirely subjective determination in Bill C-14, and given her numerous sources of suffering, including psychological suffering in the form of need for alone time and anxiety over further loss of function, when she says she is suffering enough to proceed with MAID, that satisfies the criterion.

70. While there was more caution in using shorter prognoses for interpreting reasonably foreseeable natural death in the first year, following the CAMAP Reasonably Foreseeable Clinical Practice Guideline and the A.B. v. Canada determination, some clinicians gained comfort with extending prognostic timeframes out to many years. At the time Ms. Lamb filed her civil claim, the reasonably foreseeable natural death criterion may have been a barrier to her access.

71. Based on my knowledge of current MAID practice among many providers, if Ms. Lamb were to be assessed now, and she indicated an intent to stop BiPaP and refuse treatment when she next developed pneumonia, it is likely that she would be found to meet the threshold for having a reasonably foreseeable natural death given that dysphagia is present, her lung function will deteriorate and she is clearly at risk for recurrent pneumonia.

72. As is now common practice within the MAID community, she would not be required to develop an episode of pneumonia before being approved for MAID. Most would consider it sufficient that she expresses certain intent to refuse treatment when this occurs, as she will inevitably develop a chest infection in the near future.

73. Therefore, if Ms. Lamb were requesting MAID now I believe she would be found eligible under the current eligibility criteria. She would not need to reach her feared state of invasive mechanical ventilation or to engage in voluntarily stopping eating and drinking (VSED).

74. Canadian physicians and nurse practitioners have been on a steep learning curve over the past three years in interpreting the Bill C-14 eligibility criteria. The law as it stands contains enough flexibility in the interpretation of the end of life criteria that it is not a barrier for practitioners who are comfortable with expanding access to MAID, while it serves to protect practitioners whose values do not align with removing end of life criteria for MAID. Some have commented that the flexibility in interpreting what constitutes a reasonably foreseeable natural death render the criterion meaningless as a safeguard for vulnerable patients. Rather than removing this criterion, this safeguard could be strengthened by the addition of specific prognostic requirements.

As a result, I have instructions to seek an adjournment of the trial scheduled to commence on November 18, 2018. The request is for an order *sine die.* Counsel for Canada consents.

If the Chief Justice requires a formal application and/or to hear submissions on this request, we would propose to attend on September 10th for that purpose. This is a date already set aside to hear

the parties applications to cross-examine experts and other deponents. If the Chief Justice will accept a consent order without requiring our attendance, we will do so promptly.

Needless to say that if our request for an adjournment is accepted then there is no pressing need to proceed with the application to cross-examine and we also ask that that matter be adjourned *sine die*. Canada agrees with that.

Please bring this letter to the Chief Justice with our respects and advise us if he has any directions with respect to this matter.

Yours truly,

ARVAY FINLAY LLP

Per: 

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JJA/sy
Encl.

cc Department of Justice Canada, Attn: BJ Wray and Melissa Nicolls

Responding Expert Report for Julia Lamb and British Columbia Civil Liberties Association v. Attorney General of Canada

1. I, **Madeline Li MD PhD**, am providing a responding expert report in the *Lamb* (Assisted Dying) litigation according to the Instruction Letter for Responding Expert Report as contemplated by Rule 11-6 of the *Rules of Courts* provided to me on January 17, 2019 (**Appendix 1**).

2. I am aware I have a duty to assist the court and that I may not be an advocate for any party. I have prepared this report in conformity with my duty to the court. If I am called upon to give oral or written testimony in relation to this matter, I will give that testimony in conformity with my duty to the court.

Qualifications, Employment and Educational Experience

3. I am a cancer psychiatrist and psychosocial oncology researcher, working at the Princess Margaret Cancer Centre, Toronto, Ontario since 2007. I am the Clinical Lead of the Psychosocial Oncology division within the Department of Supportive Care, a Scientist in the Princess Margaret Research Institute, and an Associate Professor in Psychiatry at the University of Toronto. Of particular relevance to this report, I am also the developer and Program Lead for the Medical Assistance in Dying (MAID) service at the University Health Network (UHN) in Toronto.

4. In educational background, I completed a combined MD PhD degree at the University of Toronto, with my PhD studies in the Department of Medical Biophysics at the Ontario Cancer Institute in the field of gene expression in cancer. After my MD, I completed a residency program in Psychiatry, followed by a clinical-research fellowship sub-specializing in cancer psychiatry and conducting research in the area of psychoneuroimmunology (PNI). My PNI research interests have been in elucidating the biological basis of psychological distress in cancer patients, with a particular focus on depression and physical symptom burden.

5. My clinical and research expertise has been in psychosocial care at the end of life, emotional distress screening, and management of anxiety and depression in cancer patients. In these areas, I have authored 35 publications, 12 book chapters, 6 practice guidelines and 12 interprofessional education resources as described in my curriculum vitae (**CV - Appendix 2**). I created the Distress Assessment and Response Tool (DART)[1] at UHN which is an emotional distress program that includes a suicide screening algorithm[2], and am currently involved in global dissemination of the DART model and in research evaluating the impact of DART on suicide incidence and prevention.

6. As psychological suffering is the main reason for assisted dying requests in all legal jurisdictions[3], I was asked to lead the development of the MAID service for the UHN. My qualifications in relation to this responding expert report are therefore based on my expertise in suicide management, depression and emotional distress interventions at the end of life, and my more recent administrative, clinical, educational and research involvement in MAID.

7. UHN encompasses four tertiary care hospitals, the Princess Margaret Cancer Centre, the Toronto Western Hospital, the Toronto General Hospital and the Toronto Rehabilitation Institute, providing care to approximately 40,000 in-patients and over 1.1 million ambulatory patients per year. I developed the implementation framework for MAID at UHN[4], and have published on our clinical experience[5-7]. I oversee the daily operations of the UHN MAID program, moderate case discussions among MAID team members who have differing opinions, and participate in the institutional MAID Operations and Quality Committees. I have provided oversight for all 210 MAID cases at UHN to February 19, 2019, and also personally conduct MAID eligibility assessments, as well as providing the MAID intervention for eligible patients at UHN.

8. At a local and national level, I represent UHN in the Canadian Association of MAID Assessors and Providers (CAMAP) and I am a member of a joint Ontario Ministry of

Health and Ontario Medical Association working group with the mandate of developing MAID Ontario Health Insurance Plan billing codes for physicians.

9. I am involved in MAID education, providing MAID educational sessions to hospital staff, and having developed the UHN intranet pages for healthcare providers (https://www.uhn.ca/healthcareprofessionals/MAID) and patients (https://www.uhn.ca/PatientsFamilies/Patient_Services/MAiD_Patients), and a MAID e-learning module (https://www.uhnmodules.ca/modules/MAID-Online-Module/story_html5.html). I have also organized and provided two community MAID training workshops for multi-disciplinary health care providers, as well as a MAID assessor and provider skills training workshop (see CV).

10. In terms of MAID research, I have been awarded two research grants to study the longitudinal emergence and predictors of MAID in advanced cancer patients (CIHR Project Grant 2018-2023), and the impact of MAID on patient quality of death and dying and caregiver bereavement (CCSRI Quality of Life Research Grant 2018-2021) and am a member of the CAMAP Research Webinar Group.

Documents Reviewed

11. In forming my opinions in this report, I reviewed the following documents related to the Canadian law on MAID, interpretation of the Canadian law, and the national and international literature on capacity assessment and assisted dying for mental disorders:

    a. A.B. v. Canada (Attorney General), 2017 ONSC 3759. (Available at https://camapcanada.ca/wp-content/uploads/2018/12/ABDecision1.pdf)

    b. Carter v. Canada (Attorney General), Supreme Court Judgments 2015 SCC5. (Accessed January 15, 2017 at https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do)

    c. Charland, Louis and Lemmens, Trudo and Wada, Kyoko, Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental

Disorders (May 25, 2016). (2016) (open volume) Journal of Ethics in Mental Health 1-14. (Available at SSRN: https://ssrn.com/abstract=2784291)

d. Council of Canadian Academies, 2018. *The State of Knowledge on Advance Requests for Medical Assistance in Dying.* Ottawa (ON): The Expert Panel Working Group on Advance Requests for MAID, Council of Canadian Academies. (Available at https://www.scienceadvice.ca/reports/medical-assistance-in-dying/)

e. Council of Canadian Academies, 2018. *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition.* Ottawa (ON): The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition. (Available at https://www.scienceadvice.ca/reports/medical-assistance-in-dying/)

f. Dembo, J., Schuklenk, U., Reggler, J. "For Their Own Good": A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) where Mental Illness Is the Sole Underlying Condition. Can J. Psych. 63:451-456, 2018.

g. Downie, J., Chandler, J.A. Interpreting Canada's Medical Assistance in Dying Legislation. IRPP Report. March 2018 (Available at http://irpp.org/research-studies/interpreting-canadas-medical-assistance-in-dying-maid-legislation/)

h. Kim SY, Lemmens T. Should assisted dying for psychiatric disorders be legalized in Canada? Can. Med. Assoc. J. 2016 188:E337-E339, 2016.

i. Rousseau S, Turner S, Chochinov HM, Enns MW, Sareen J. A National Survey of Canadian Psychiatrists' Attitudes toward Medical Assistance in Death. Can J Psychiatry. 62:787-794, 2017.

j. Shaw, D., Trachel, M, Elger, B. Assessment of decision-making capacity in patients requesting assisted suicide. Br. J. Psych. 213:393-395, 2018.

k. Simpson, A.I.F. Medical Assistance in Dying and Mental Health: A Legal, Ethical, and Clinical Analysis. Can. J. Psych. 63(2):80-84, 2018

l. Statutes of Canada 2016. Chapter 3. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). June 17, 2016, Bill C-14. (Accessed January 15, 2017 at http://www.parl.gc.ca/content/hoc/Bills/421/Government/C-14/C-14_4/C-14_4.PDF).

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12. In addition to the documents listed above, I have also reviewed documents related to No. S-165851: In the Supreme Court of British Columbia between Julia Lamb, British Columbia Civil Liberties Association and Attorney General of Canada:

- Further Amended Notice of Civil Claim, September 17, 2018
- Response to Further Amended Notice of Civil Claim Facts, October 4, 2018
- 2nd Affidavit of Julie Lamb, December 13, 2018
- Video of Julia Lamb at BCCLA press conference on June 27, 2016: https://youtu.be/azCIMjO9KnM
- Expert Report of Dr. Justine Dembo, *Julie Lamb and British Columbia Civil Liberties Association v. Attorney General of Canada*, SCBC Vancouver Registry No. S-165851. December 14, 2018.

13. In addition to the above, my opinions are further based upon empirical evidence from communications within the MAID community – discussions within the UHN MAID teams, on-line MAID discussion forums (CAMAP, Ontario MAID Community of Practice (CoP), GTAMAID, OntarioMAID, Ontario College of Family Physicians), and individuals with the Ontario MAID Care Co-ordination Service and Dying with Dignity Canada.

In Response to the Expert Report of Dr. Dembo

Question 1: In response to Dr. Dembo's discussion of capacity and consent evaluations in the context of MAID, are there risks and vulnerabilities that may not be identified through stringent capacity and consent evaluations? If so, please provide examples.

14. Several limitations with respect to capacity and consent evaluations for MAID were not discussed in Dr. Dembo's expert report. These include 1. uncertainty regarding the conceptualization and assessment of capacity in the context of chronic, non-

terminal medical conditions[8], 2. that voluntariness and non-ambivalence are adequately considered in MAID assessments, and 3. the gap between the ideal state where physicians have the skill to conduct rigorous MAID capacity assessments and the reality where this is only superficially done, particularly in the context of euthanasia for mental disorders[9]. I will expand upon each of these in turn.

15. Dr. Dembo accurately describes the minimum elements of capacity assessment in general medical decision-making according to the Applebaum guidelines[10] and which are utilized in the McArthur Competence Assessment Tool-Treatment (McCAT-T). This tool focuses on only the cognitive aspects of capacity - understanding, appreciation, reasoning and ability to express a choice – which represents a low bar that only those with significant cognitive impairment would fail to reach. It assumes personal decision making based purely on logical thought, with no evaluation of the rationality of emotional thinking[c]. Emotions such as hope, anger, sadness, anxiety, and hedonia (the ability to experience pleasure) also strongly influence treatment decisions, and can be rational or irrational, yet they are not standardly evaluated during capacity assessments. Exclusive reliance on a purely cognitive approach to capacity results in the superficial capacity assessments reported in 55% of the Dutch cases of euthanasia for psychiatric disorders[9].

16. While there are many policies and guidelines on medical capacity assessment, most legal definitions include only the ability to **understand** the information relevant to making a treatment decision and **appreciate** the reasonably foreseeable consequences of a decision. The minimally required components of this *appreciation* are subject to interpretation and as such, there is no clearly agreed upon clinical definition of capacity.

17. It has been suggested that in the context of MAID, and particularly where mental disorders are concerned, capacity assessment should include evaluation of wider concepts such as sociocultural rationality (i.e. evaluation of a patient's values against societal norms), undue internal influence on voluntariness, and the emotions

and values motivating the MAID request[8,c, e,]. Such dimensions are real life elements of clinically valid and ethically sound capacity assessment. However, there are currently no available capacity assessment tools to evaluate these dimensions to adequately protect vulnerable populations. Examples of these concerns are further elaborated upon below and in response to Question 2.

18. Dr. Dembo similarly describes voluntariness and non-ambivalence in basic legal terms, which do not always adequately provide for the clinical vulnerabilities observed in MAID cases. Her definition of voluntariness is restricted to non-coercion from external pressure and it is primarily discussed with respect to providing informed consent. In addition to the external pressures of stigma and the psychosocial vulnerabilities described in paragraph 46 of my Expert Report with respect to chronic health conditions including mental disorders, mental disorders by their nature can exert undue internal influence on the voluntariness of a patient's decision making, an important consideration when only cognitive capacity criteria appear to be met.

19. Desire for death can be a core symptom of disorders such a major depression and pathological anxiety or anhedonia can have the effect of rendering a patient's decision making non-autonomous[e], thereby unduly influencing the voluntariness of their decision. When such symptoms are not severe enough to impair cognitive capacity, it is extremely challenging, for both psychiatrists and other physicians, to distinguish the difference between a rational and a pathological desire for death. As stated in the CCA expert panel report on MAID for mental disorders[e], "However, a capable person's wishes cannot legally be overruled, even if a clinician believes they are not autonomous because a mental disorder has influenced their decision-making".

20. A recent UHN case illustrating this scenario was a woman with transfusion-dependent myelofibrosis, and a long history of chronic depression. Her depression was treated and in partial remission, but she refused further anti-depressant

optimization as her myelofibrosis was progressing and she decided to stop blood transfusions and receive MAID instead. As the first dose of a new cancer treatment had caused intolerable side effects, her oncologist and psychiatrist supported her decision making. She was assessed by two very experienced MAID providers in the community, deemed to be competent and approved. Her 10 day reflection period lapsed, but in a moment of medical crisis before she had set a date for MAID, she chose to be admitted to hospital for treatment. In hospital, she then decided to go home and receive MAID. The day before her planned MAID intervention, she changed her mind and decided to pursue a purely palliative approach. During a subsequent medical crisis, she again chose to be admitted to hospital, and then a few days into her admission, requested MAID again. Her MAID physician considered this her process in deciding on a date and did not consider her request to be withdrawn or have concerns about her ambivalence or capacity. Two days before her planned MAID intervention she changed her mind again. She then agreed to re-start blood transfusions, and subsequently agreed to continue with new cancer therapies.

21. This case illustrates how challenging it can be to distinguish a rational request for MAID and one driven by anxiety and depressive symptoms, despite stringent capacity and consent evaluation by the usual legal criteria. It also illustrates how complex the evaluation of non-ambivalence is in the context of mental disorders, and how the safeguards Dr. Dembo notes of physician being "trained to look for ambivalence", the 10 day waiting period, assessments by different physicians over time, and enduring suffering, are insufficient in such cases. Although the principles of non-ambivalence and protecting against impulsive requests ("Whereas vulnerable persons must be protected from being induced, in moments of weakness, to end their lives") are described in both Bill C-14[I] and the Carter decision, they are not always achievable in practice.

22. Finally, Dr. Dembo's statement regarding MAID decisions where there may be more potential years of life lost - "I instinctively apply greater caution and rigour. My

understanding is that other physicians would also do so because this is consistent with our general approach" – is inconsistent with both existing research and empirical evidence. Physician knowledge and training in general medical decision-making capacity assessment is lacking[11], and the international experience of the quality and concordance between capacity assessments for psychiatric patients requesting euthanasia is poor[9,12].

23. A review of psychiatric euthanasia cases in the Netherlands showed that in 24% of cases, physicians disagreed about capacity assessment, but euthanasia proceeded anyway, and in 11% of these cases, there was no psychiatric assessment[12]. In the Dutch review of psychiatric euthanasia cases, there was disagreement in the capacity evaluation in 12% of cases, but the review committee accepted the approvals without judgement[9]. In 55% of these cases patients were assessed with a low threshold for capacity, with such global capacity statements as saying the patient was competent "in general", while documenting that their ability to "use information in a rational way was doubtful"[9].

24. As there is generally no central co-ordination of an individual's MAID assessment process enabling communication between providers, individuals with chronic health conditions who are deemed incapable by one provider are free to continue seeking an indefinite number of eligibility assessments until they eventually find assessors who will find them eligible. This is likely to occur as there is high variability in the rigor or application of the standards and interpretation of the law between providers.

25. Studies have shown that physicians' personal opinions regarding assisted dying can influence their eligibility evaluations. A national survey of American psychiatrists found that those with ethical objections to assisted suicide advocated for higher competency thresholds and more stringent assessment criteria[14], whereas a survey of psychiatrists in Oregon showed that those who are stronger advocates for assisted suicide were less concerned that it would be misused with disadvantaged persons[15]. A 2017 review of Due Care Not Met (DCNM) euthanasia cases in the

Netherlands demonstrated that physicians from euthanasia advocacy organizations push the limits of the euthanasia laws and account for over 50% of the DCNM cases, as compared to their involvement in only 5% of all euthanasia cases in the Netherlands[16].

26. Empirically, I have observed within the MAID community a lack of understanding of basic capacity and consent processes, and a repeated and incorrect delegation of complex capacity assessments to psychiatric consultants who are not conducting full MAID eligibility assessments. This is a common misunderstanding I encounter as a medical psychiatrist where I am frequently asked by referring physicians to provide an opinion on a patient's capacity for even general medical treatment decision making.

27. I have observed some practitioners within the MAID community say that they have yet to find a patient lacking capacity, and others who believe there is a "global decision making capacity" that can be obtained from consulting a psychiatric expert. Most indicate that for complex capacity assessments, particularly those involving psychiatric co-morbidities, they would obtain a psychiatric capacity assessment. Their resultant capacity assessment is comprised simply of "a psychiatrist deemed the patient capable". However, this is neither a technically correct nor a rigorous quality practice.

28. According to the Ontario Health Care Consent Act[n], capacity is treatment specific and must be determined by the physician proposing the treatment. There is no such thing as global decision making capacity, and while a psychiatrist can provide an opinion that informs the assessment of the MAID provider, the psychiatrist's opinion has no legal weight. The treating physician (or MAID provider in this case) is the one who is legally responsible for assessing and determining capacity, as they are the only ones who can consent the patient in terms of discussing risks, benefits, and alternatives.

29. Psychiatrists can provide an opinion on whether a psychiatric disorder is impairing a patient's judgment, but this is distinct from assessing a patient's capacity to consent to MAID, which as described above, can be a particularly nuanced and challenging assessment in the context of mental illness. Therefore, in terms of quality of care, it is the MAID eligibility assessor who must be the expert in MAID capacity assessment. As stated in paragraph 25, research has shown that capacity assessment is influenced by the psychiatrists' attitude towards assisted dying[14,15], and a national survey of Canadian psychiatrists' attitudes demonstrate that less than 30% are in favour of MAID on the basis of mental illness[17].

30. As discussed earlier, the challenge of capacity assessment for MAID in patients with psychiatric illness is determining whether their psychiatric state is driving the MAID request or impairing their evaluation of what life without MAID would be like. However, this is challenging for anyone to assess and psychiatrists will be no better than any other physician, as this type of evaluation has never previously been part of medical school curricula, and there is limited research evidence to inform it. This clinical uncertainty likely motivates the desire to consult a capacity expert, but the reality is that in this new area of MAID for patients with psychiatric disorders, there are no experts.

Question 2: To what extent do you agree with Dr. Dembo's assertion at paragraph 26 of her report that it is possible for physicians to distinguish between a rational wish to die in order to end intolerable suffering arising from a medical condition, and suicidal ideation.

31. While I agree with Dr. Dembo that there is a distinction between a rational wish to die in order to end intolerable suffering arising from a medical condition (i.e. rational desire for death) and a pathological wish to die driven by a mental disorder (i.e. irrational desire for death), I favour a semantic difference of opinion in emphasizing that both are forms of suicidal ideation, and I would assert that it is not always possible to distinguish them.

32. As Dr. Dembo emphasizes, the Canadian Mental Health Association's definition of suicide as an "impulsive, violent, act, carried out in secrecy" refers to irrational suicidal acts in the context of mental illness or situational or relational crises. However, under Bill C-14[I,] self-administered MAID is considered a form of suicide. In paragraph 26(iii), Dr. Dembo states that "Physicians other than psychiatrists also receive training in assessing the difference between a rational wish to die…and suicidal ideation". However, this specific education is only now being newly introduced into the medical curriculum since passage of Bill C-14. Prior to the legalization of MAID, medical education on suicide was focused solely on detection and prevention and this occurred only within core psychiatry rotations.

33. Dr. Dembo emphasizes that assessment for suicidal ideation is already routinely done as part of decisions around withdrawal of life sustaining treatment. In my clinical experience, this assessment is cursory where there is no concern for mental illness. In complex cases such as the controversial practice of withdrawal of life support after a failed attempted suicide, intensivists and hospitalists will defer the assessment of irrational suicidal ideation to a consultant psychiatrist, as physicians other than psychiatrists are generally not adequately trained to assess the difference between a rational wish to die and suicidal ideation. This is a larger concern in the context of MAID assessments, where psychiatric consultation is neither required by law, nor readily available in the community. Therefore, MAID providers will frequently be trying to distinguish rational and irrational suicidal ideation themselves.

34. Within the MAID community there have been frequent discussions of patients who threaten to commit suicide if denied MAID, and I have noted that many clinicians appear to have limited knowledge of suicide assessment and prevention. Even acknowledging that many of these patients have had previous psychiatric involvement and some would have personality disorders, uncertainty is commonly expressed around whether, when and how to invoke the Mental Health Care Act to involuntarily admit a patient to protect them from suicide. This is another gap - between any theoretical possibility of distinguishing rational and irrational suicidal

ideation, and the practical reality of whether it can or does happen during complex MAID assessments.

35. Physicians other than psychiatrists report very little comfort in assessing suicide risk and often do not view suicide assessment as falling within their scope of practice[18,19]. My experience with implementing the PHQ-9 depression screen[2], which includes a single question tapping suicidal ideation, within the Distress Assessment and Response Tool program[1] has been that physicians are very reluctant to screen for and assess suicidal ideation. Our chart audits for physician response to the suicidal screen in DART showed that when patients report suicidal ideation, it is assessed by the physician only 9% of the time[20]. This is consistent with the trend in American programs to conduct depression screening with the PHQ-8, removing the suicidal ideation item from the PHQ-9[21].

36. When assessment of even clearly irrational suicidal ideation is poor among non-psychiatric physicians, it is to be expected that training, comfort and experience with assessing more complex suicidality, such as the undue internal influence of mild to moderate depressive symptoms as described in paragraph 20, is still more lacking. If not of sufficient severity to impair capacity as currently assessed by cognitive criteria, emotional symptoms of depression such as anhedonia or guilt over being a burden to others can contribute to depressive suicidal ideation of borderline rationality, which becomes indistinguishable from rational suicidal ideation.

37. As a psychiatrist specializing in palliative care, I frequently encounter patients with demoralization[22] a clinical syndrome marked by feelings of hopelessness, helplessness, a sense of failure and the inability to cope. Demoralization is a core concept in the field of psychosocial oncology, with over a decade of extensive research and meta-analytic description[23, 24]. It is distinct from depression and is strongly associated with the Wish to Hasten Death[25] (described in paragraph 49 of my Expert Report), which is considered a form of irrational suicidal ideation. Although it is not yet formally included within the DSM-5 as a mental disorder, there

is clear recognition that the current psychiatric nosology inadequately captures the psychological suffering that can have extreme negative impacts on patient's quality of life[26]. Like depression, demoralization exists on a continuum from disheartenment to despondency to despair and finally full demoralization syndrome, which is a pathological condition frequently leading to requests for MAID[27].

38. In recent discussions among the on-line MAID community, most practitioners had very little knowledge or understanding of the concept of demoralization and therefore were not considering it during their MAID assessments. In psychosocial oncology, demoralization/WTHD have long been regarded as intervention targets. Yet demoralization essentially is a form of psychological suffering, which is the main reason for MAID requests.

39. The WTHD is a passive wish that the end would come sooner rather than later[25]. It is strongly associated with depression and physical suffering and improved with good symptom control. It is distinguished from an irrational desire for death or a rational desire for MAID based on the more active intent in the latter two. As Dr. Dembo states, an irrational desire for death is distinguished from MAID by being an impulsive, incapable act driven by mental illness, which also improves with treatment of the mental illness. Desire for MAID describes a scenario where a patient is capable and not driven by mental illness, and most often symptom relief does not reduce the desire for MAID, because it is usually motivated by more existential issues which are in fact, irremediable.

40. The practical problem is whether you can distinguish demoralization/WTHD, rational desire for death (e.g. MAID), and irrational desire for death (e.g. suicide). Although I do consider demoralization in every MAID assessment, I find it practically impossible to distinguish from a desire for MAID when the patient has made a MAID request. There are many measures of demoralization, but they are not helpful in formally addressing the issue. Patients are not required to accept any interventions for demoralization and we must accept this. A demoralized patient (like a depressed

patient) can refuse help for this, and they can still be eligible for MAID so long as they are capable (plus all other criteria). In fact, demoralized patients often do not meet diagnostic criteria for Major Depression and therefore may meet the purely cognitive threshold for capacity. It is a critical, but difficult to answer, question whether they can realistically appreciate the reasonably foreseeable consequences of not receiving MAID.

41. In response to Dr. Dembo's assertion that "In assessing capacity and consent for medical decision-making in general, physicians do account for suicidality" (paragraph 26(iv)), even physicians in the MAID community with decades of palliative care experience were surprised to have never heard of demoralization and WTHD as potential forms of irrational suicidal ideation. This makes it highly unlikely that it is accounted for as part of suicide assessment, such that the ideal rigour Dr. Dembo asserts is applied during capacity and consent evaluations for medical decisions resulting "death or a greater number of years of life lost" (paragraphs 26(v) and 26(vi)), does not occur.

42. This is in part because even with my knowledge and experience in psychiatry, illness-related psychological suffering, and as a MAID assessor, I find it essentially impossible to demarcate when demoralization or depression makes a desire for death irrational. Demoralization is closely associated with death anxiety[28], not the usual death acceptance typical of a rational desire for death. The patient described in paragraph 20 likely had some degree of demoralization, and her death anxiety resulted in ambivalence about MAID, yet she was assessed and approved.

43. There is also concern regarding the cognitive bias most often used in capacity assessments and lack of consensus on standards for more broadly assessing capacity in vulnerable patients with depression or demoralization. A personal compromise for me is to pragmatically accept the infrequent false positive or type I error (i.e. approving MAID for an irrational desire for death) in patients whose natural death is reasonably foreseeable anyway.

44. As Dr. Dembo repeatedly indicates, physicians who are uncomfortable with suicide risk assessment will usually refer the patient to a colleague or psychiatrist for assessment. As described in paragraph 26 above, this is problematic where the need is to distinguish rational and irrational suicidal ideation. Clear cut irrational suicidal ideation driven by psychosis or severe major depression can be distinguished from rational suicidal ideation driving MAID requests, and this does not require the expert assessment of a psychiatrist. However, in cases of more mild to moderate psychiatric disturbance such as demoralization, it becomes extremely difficult to distinguish rational from irrational suicide. As previously stated, for this scenario, there are no experts.

45. Two experimental case studies illustrate the challenge of distinguishing rational from irrational suicidal ideation[29] in mild depression. I am involved in a clinical trial of ketamine as a rapidly acting antidepressant in patients with cancer receiving palliative care. Our first two study participants had also requested MAID and their assessors were uncertain of eligibility due to partially treated depressive symptoms. Patient #1 was requesting MAID because she was unable engage in any pleasurable activities, and as she pragmatically accepted the inevitability of death, she saw no point in prolonging her dying. However, she felt guilt over choosing to leave her family and could not select a date to receive MAID. Patient #2 also requested MAID because she was anhedonic and unable to enjoy any quality of life. She felt guilty for burdening her family and did not want to increase their suffering by prolonging her inevitable death.

46. Both participants had a clinically significant reduction in depressive symptoms with ketamine, with complete resolution of anhedonia and feelings of guilt. For Patient #2, this resulted in a reduction in her desire for death and she withdrew her MAID request. In retrospect, it might be concluded therefore that her suicidal ideation was largely driven by her depression. For Patient #1, despite being able to enjoy more daily activities, with resolution of her guilt, her intent to receive MAID intensified as

she prioritized more her own value system and accepted leaving her family was inevitable. In retrospect, her suicidal ideation appeared to be driven more by the pragmatic desire not to unnecessarily prolong dying.

47. In these cases, ketamine served as a “litmus” test for clarifying the impact of depression on the desire for death, but this cannot be relied upon as a capacity assessment tool for MAID. First, it is unclear how reproducible or generalizable this finding will be and second, it is also notable that not all patients with depression or demoralization who request MAID will accept a trial of ketamine. For example, the patient described in paragraph 20 was eligible for the ketamine study, but refused further antidepressant trials. Ketamine for depression remains an experimental intervention, with only limited availability as an off-label indication in Canada.

Question 3: In response to paragraphs 30-33 of Dr. Dembo’s report, what concerns arise if medical assistance in dying is made available to individuals whose sole medical condition is mental illness?

48. I am in agreement with Dr. Dembo’s opinion that a refractory mental disorder can cause a patient unbearable suffering. However, the question remains as to whether MAID is the appropriate response to this suffering. The concerns I described related to removing the end of life criteria in paragraph 36 of my Expert Report, also apply to MAID being made available to individuals whose sole medical condition is mental illness. Specifically these were a lack of understanding as to whether the Canadian populace are in favour of MAID solely for mental illness, the unintended consequence of reducing physician and nurse practitioner engagement in providing MAID, and insufficient safeguards in the current law for this vulnerable population.

49. I will not repeat the discussion of these points, but will describe concerns related to the existing legal criteria for MAID with respect to mental illness and cautions that should be taken from other jurisdictions where psychiatric euthanasia is permitted.

50. The expansion of MAID solely for mental illness will increase the frequency of complex capacity assessments with type I error as described in paragraph 43. In addition to the challenges as described above of adequate capacity assessment and distinguishing between rational and irrational suicidal ideation, there are several other vulnerability points in opening access to MAID for mental illness which will further increase type I error (i.e. failing to protect a vulnerable individual).

51. It is not clear in mental illness when a disorder is truly irremediable. Treatment-resistance in psychiatric disorders is a retrospective concept resulting from lack of response to previous treatment trials. It does not mean impossibility of response to future treatment[30]. Psychiatric diagnoses are based purely on clinical criteria and are syndromal in nature, resulting in a highly heterogeneous presentation within each diagnosis. As a result, it is impossible to accurately predict treatment response for an individual patient[30].

52. There is also a concern related to the entirely subjective determination of suffering in Bill C-14[l]. In the Netherlands, Belgium and Luxembourg, all jurisdictions in the world where psychiatric euthanasia is legal, the physician must objectively determine that the suffering is unbearable and irremediable[e]. Unlike cancer which can be either cured or not, response to treatment for mental illness falls on a spectrum, and when objectively measured is described as symptom reduction representing response, remission or recovery[31]. This leaves room for patients with residual symptoms of mild to moderate severity, which may not impair capacity, but for whom subjective unbearable suffering without objective evaluation requires us to reflect on how society chooses to balance respect for autonomy vs protecting the vulnerable.

53. Related to the challenges in defining treatment effectiveness, psychiatric disorders do not necessarily follow a trajectory of irreversible decline in capability. More often they present with a fluctuating loss of function[32]. Even without treatment, there is a relapsing/remitting nature to symptom episodes for example in mood disorders. It will be extremely challenging to ensure protection of a vulnerable patient requesting

MAID in the course of a symptom flare in terms of sustained desire and their natural symptom course. Determining a sufficient time frame for a reflection period for mental disorders will be extremely challenging, but should certainly be longer than 10 days.

54. A significant concern relates to treatment refusal and how this can be iatrogenic (i.e. inadvertent harm to the patient caused by medical care) in the context of MAID for mental disorders. Even in the context of medical illness, I have observed that knowledge of the availability of MAID results in some patients refusing to even try treatments which may relieve their suffering and in one case refuse potentially curative treatment (paragraph 54 of my Expert Report). This would likely become far more problematic in mental health conditions where treatment refusal is common due to lack of insight, perceived stigma and sometimes amotivation arising from the illness. A review of 66 Dutch completed psychiatric euthanasia cases showed that 56% refused at least some recommended treatment, and physicians disagreed about treatment futility in almost 25% of the cases[12].

55. A further complication is that treatment compliance in patients with psychiatric disorders is strongly influenced by the relationship with the psychiatrist[33]. This is particularly true in patients with personality disorders, which account for over half of the psychiatric euthanasia cases in Belgium[34]. Transference and countertransference issues in the physician-patient relationship are highly complex in the context of a patient's euthanasia request, testing such themes as caring, protection, abandonment, control or respect. This may have the effect of inducing vulnerable patients to end their lives.

56. A survey of Dutch consulting psychiatrists found that in only 4% of all assisted death requests was psychiatric consultation sought, and in only 24% of these was assessment of the influence of transference and countertransference requested[35]. Recent Dutch statistics on completed euthanasia or assisted suicides for personality disorders show that psychiatric treatment had never been tried in over 27% of

patients and 70% of the physicians providing euthanasia were non-psychiatrists using only assessment of the patient at the present time, without knowledge of their psychiatric history[36].

57. A further concern is the striking disproportion of women receiving psychiatric euthanasia in legal jurisdictions. For non-psychiatric conditions, men and women access assisted dying equally. For psychiatric euthanasia in the Netherlands, the ratio of women to men is 2.3 to 1[12] and in Belgium over 77% of cases of psychiatric euthanasia occurred in women[37]. This exceeds the known sex differences in mood disorders and personality disorders, and matches the sex ratio in suicide attempts in the general population[12]. This finding underscores the challenges in distinguishing rational and irrational suicidal ideation in psychiatric populations, a finding further substantiated by the increasing incidence of medically assisted suicides in patients with depression in Oregon[38].

58. Finally, the potential risk of undermining suicide prevention efforts by normalizing suicide in society has been extensively discussed[c]. It is unclear if physicians would be less vigilant in suicide prevention efforts, and there is no evidence that legalized psychiatric euthanasia increases non-assisted suicide rates, but the emerging trend and even suggestion by some MAID advocacy groups to employ VSED (voluntarily stop eating and drinking) as a means to MAID is a concerning blurring of what constitutes a suicidal act. This lends support to the plausibility of a social contagion effect on suicide rates from legalizing MAID for mental disorders[39].

In Response to Ms. Lamb's Affidavit #2:

Question 1: Based on your review of Ms. Lamb's affidavit and your experience as a MAID assessor and provider, if Ms. Lamb requested MAID now, would she meet the eligibility requirements of the existing medical assistance in dying law? Why or why not?

59. I have insufficient information based solely on the Ms. Lamb's affidavit and the June 2016 BCCLA press conference video I viewed to determine her full eligibility for MAID under the existing law. I am uncertain of her eligibility based on two Bill C-14[l] criteria which are not being challenged in the current claim - 241.2(1)(e) and 241.2(2)(c).

60. *241.2(1)(e) – "they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care"*. It is unclear to me if Ms. Lamb is providing informed consent to receive MAID at the current time. This is not explicitly specified in the claim documents I reviewed, but I have seen in media reports that she is seeking the right to have MAID at some time in future when her suffering is of sufficient severity.

61. MAID cannot currently be approved as an advance request[d], and as with any medical intervention, patients are generally not consented for procedures unless they are to receive them in the near future. This is because their clinical condition and capacity may change over time, altering the discussion of risks and benefits as part of informed consent, and their eligibility assessment. Although there is no agreed upon standard time after which MAID eligibility approvals are considered to have expired, the Canadian Medical Protective Association (CMPA) has repeatedly advised physicians that if a prolonged period of time lapses between MAID approval and when a patient chooses to receive MAID, they would need to be completely re-assessed.

62. Further, the CMPA has advised that 241.2(1)(e) implies the patient is consenting to receive MAID *instead* of alternative interventions to relieve suffering, including palliative care. It is unknown if Ms. Lamb has been offered palliative care services which may relieve her pain and suffering, but she appears to be continuing to pursue active treatment interventions, including the use of BiPaP, treatment for pneumonia when it occurs, and supportive care interventions such as mobility devices,

physiotherapy and personal care aides. This suggests no intent to receive MAID in the near future.

63. *241.2(2)(c) – "that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable".* Although it is clear that Ms. Lamb is suffering now, it is unclear if this is currently intolerable to her. She initiated this claim over two years ago, at which time she stated that she was seeking MAID approval on the basis of anticipated future intolerable suffering. Therefore, it would appear that at the time she initiated this claim her suffering was not intolerable, and as stated above, interventions to help relieve her suffering were acceptable to her.

64. She stated in her video that not knowing whether she could access MAID in future was causing her current psychological suffering, but paradoxically this psychological suffering would be relieved by being approved for MAID and appears to be at least ameliorated by this legal challenge.

65. Without knowing whether she now intends to stop active treatments such as BiPaP or antibiotics if pneumonia were to recur and wants to receive MAID instead, I am unable to comment on her current eligibility within the existing MAID law. However, my uncertainties are not related to whether she has an incurable condition, advanced state of irreversible decline in capability or reasonably foreseeable natural death. I believe she would currently meet all three of these criteria, as described further below.

Question 2: In your opinion, if Ms. Lamb requested a medically assisted death at a future date, would she meet the eligibility requirements of the existing medical assistance in dying laws? Why or why not?

66. When Ms. Lamb clearly expresses an intent to receive MAID, either now or at a near future date, I believe she would meet all eligibility requirements of the existing MAID

law, including all current criteria for having a grievous and irremediable medical condition, as detailed below.

67. Spinal Muscular Atrophy Type 2 is clearly a progressive, incurable condition.

68. As she is unable to walk, turn in bed, attend to her own activities of daily living, and she struggles with writing, swallowing, and breathing during sleep, she clearly meets threshold for being in an advanced state of irreversible decline in capability.

69. Intolerable suffering is an entirely subjective determination[g] in Bill C-14[l], and given her numerous sources of suffering, including psychological suffering in the form of need for alone time and anxiety over further loss of function, when she says she is suffering enough to proceed with MAID, that satisfies the criterion.

70. While there was more caution in using shorter prognoses for interpreting reasonably foreseeable natural death in the first year, following the CAMAP Reasonably Foreseeable Clinical Practice Guideline[m] and the A.B. v. Canada determination[a], some clinicians gained comfort with extending prognostic timeframes out to many years. At the time Ms. Lamb filed her civil claim, the reasonably foreseeable natural death criterion may have been a barrier to her access.

71. Based on my knowledge of current MAID practice among many providers, if Ms. Lamb were to be assessed now, and she indicated an intent to stop BiPaP and refuse treatment when she next developed pneumonia, it is likely that she would be found to meet the threshold for having a reasonably foreseeable natural death given that dysphagia is present, her lung function will deteriorate and she is clearly at risk for recurrent pneumonia.

72. As is now common practice within the MAID community, she would not be required to develop an episode of pneumonia before being approved for MAID. Most would

consider it sufficient that she expresses certain intent to refuse treatment when this occurs, as she will inevitably develop a chest infection in the near future.

73. Therefore, if Ms. Lamb were requesting MAID now I believe she would be found eligible under the current eligibility criteria. She would not need to reach her feared state of invasive mechanical ventilation or to engage in voluntarily stopping eating and drinking (VSED).

74. Canadian physicians and nurse practitioners have been on a steep learning curve over the past three years in interpreting the Bill C-14[l] eligibility criteria[g]. The law as it stands contains enough flexibility in the interpretation of the end of life criteria that it is not a barrier for practitioners who are comfortable with expanding access to MAID, while it serves to protect practitioners whose values do not align with removing end of life criteria for MAID. Some have commented that the flexibility in interpreting what constitutes a reasonably foreseeable natural death render the criterion meaningless as a safeguard for vulnerable patients. Rather than removing this criterion, this safeguard could be strengthened by the addition of specific prognostic requirements.

Question 3: If Ms. Lamb did not meet the eligibility requirements for MAID under the existing law, what other options would be available to her to deal with intolerable suffering?

75. Ms. Lamb is obviously an extraordinarily resilient woman who has demonstrated a remarkable capacity to adapt and cope with a serious life-long disability. She has already accessed and made good use of available disability supports to achieve major life milestones despite her SMA. This bodes well for her ability to continue adapting both physically and psychologically as her SMA progresses, and to engage in and benefit from supportive care services.

76. To further support her in relieving symptoms and optimizing quality of life, she could be referred to palliative care and psychosocial counseling. Palliative care interventions are highly effective in alleviating physical symptoms such as pain or

breathlessness and evidence is growing for early palliative care interventions significantly improving patient's quality of life[40].

77. There are also several psychological interventions, including Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy (CBT), Dignity Therapy, or Meaning Centred Psychotherapy that would address the psychological suffering which contributes to the desire for MAID.

78. If close to the end of life, she lost capacity or was unable to or chose not to undergo the MAID process, continuous or intermittent palliative sedation[41] would be available to her for intractable symptoms. The goal of palliative sedation is to induce unconsciousness to relieve intractable symptoms, without the intent to hasten death. It can be provided at the discretion of the physician without the onerous MAID assessment process, can be provided urgently for symptom crisis, and specified as an advance directive or authorized by a substitute decision maker.

Sole Author

I confirm that I am the sole author of this report and all opinions in the report are my own.

March 16, 2019

Madeline Li MD PhD FRCP(C) Date
Psychiatrist, Psychosocial Oncology and Palliative Care
University Health Network - Princess Margaret Cancer Centre
16 – 749 610 University Avenue, Toronto, ON M5G 2M9
phone: 416-946-4501 ext. 7505 fax: 416-946-2047
e-mail: madeline.li@uhn.ca

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Appendix 1

Department of Justice Canada | Ministère de la Justice Canada

Business and Regulatory
900 - 840 Howe Street
Vancouver, British Columbia
V6Z 2S9

Telephone: (604) 666-4304
Facsimile: (604) 775-5942

January 17, 2019

By Email to: Madeline.Li@uhn.ca

Dr. Madeline Li
Princess Margaret Hospital
16-749, 610 University Ave.
Toronto, ON M5G 2M9

Dear Dr. Li:

Re: ***Julia Lamb and the British Columbia Civil Liberties Association v. the Attorney General of Canada***

Instruction Letter for Responding Expert Report as contemplated by Rule 11-6 of the *Rules of Court*

Please find attached the expert report of Dr. Dembo, dated December 14, 2018 and the Affidavit #2 of Ms. Julia Lamb, dated December 13, 2018. As dicussed, I would ask that you review these materials and provide a responding report to each of the questions that I have set out below.

Background Information

As you are aware, the plaintiffs in the above noted case claim that certain provisions in Canada's medical assistance in dying ("MAID") legislation violate Canada's *Charter of Rights and Freedoms*. Among other things, they say that the legislation's requirement that a person's natural death has become reasonably foreseeable before they may be eligible for medical assistance in dying infringes their rights to life, liberty and security of the person.

It is the AGC's position that the assisted dying legislation is constitutional and strikes an appropriate balance between the autonomy of those individuals seeking access to medical assistance in dying and the interests of vulnerable persons and of society.

Questions for Your Expert Report

Please answer the following questions in response to the expert report of Dr. Dembo.

1. In response to Dr. Dembo's discussion of capacity and consent evaluations in the context of MAID, are there risks and vulnerabilities that may not be identified through stringent capacity and consent evaluations? If so, please provide examples.

2. To what extent do you agree with Dr. Dembo's assertion at paragraph 26 of her report that it is possible for physicians to distinguish between a rational wish to die in order to end intolerable suffering arising from a medical condition, and suicidal ideation.

3. In response to paragraphs 30-33 of Dr. Dembo's report, what concerns arise if medical assistance in dying is made available to individuals whose sole medical condition is mental illness?

Please answer the following questions with respect to Ms. Lamb's Affidavit #2:

1. Based on your review of Ms. Lamb's affidavit and your experience as a MAID assessor and provider, if Ms. Lamb requested MAID now, would she meet the eligibility requirements of the existing medical assistance in dying law? Why or why not?

2. In your opinion, if Ms. Lamb requested a medically assisted death at a future date, would she meet the eligibility requirements of the existing medical assistance in dying laws? Why or why not?

3. If Ms. Lamb did not meet the eligibility requirements for MAID under the exsiting law, what other options would be available to her to deal with intolerable suffering?

Format of Your Expert Report

Your report must be prepared in accordance with the British Columbia *Rules of Court*. As such, we ask that you do the following within the body of your report:

1. Set out a summary of your qualifications and employment and educational experience, indicating your area of expertise and attach a copy of your current curriculum vitae to your report;

2. State the issues that you have been asked to address and attach a copy of this instruction letter to your report;

3. Set out your opinions respecting each issue you have been asked to address and the reasons for your opinion;

4. Identify and list the documents that you have reviewed in forming your opinions and set out any assumed facts on which your opinions are based. You may also wish to append relevant publications to your expert report;

5. Please confirm you are the sole author of your report. If you wish to rely on someone else to assist you in preparing the report, please obtain our prior consent. If someone else is relied on by you, they must be clearly identified in the report. All of the opinions in the report must be your opinions;

6. An expert's duty is to the Court and an expert must not be an advocate for any party. While you are retained by one party to this lawsuite, your professional duty is to provide impartial advice and your honestly held opinions. You must understand this duty and you are required to certify you are aware of your duty to the Court, that your expert report is written

in accordance with that duty, and that you will give testimony in accordance with that duty if required to do so. Accordingly, please include the following statement in your report:

> *I am aware I have a duty to assist the court and that I may not be an advocate for any party. I have prepared this report in conformity with my duty to the court. If I am called upon to give oral or written testimony in relation to this matter, I will give that testimony in conformity with my duty to the court.*

7. Please number each paragraph of your report as this will aid us in referring to your report in Court.

Working File

As discussed, your working file, including all of your notes, working papers and correspondence, will be privileged and not subject to disclosure until such time as the Rules require us to provide them to the plaintiffs. At that time, privilege is lost and the plaintiffs are entitled to review your working file.

It is the practice of some experts to retain early drafts of their reports and it is the practice of other experts to routinely dispose of such drafts as they are revised. If it is your practice to dispose of such drafts upon revision, you are entitled to do so. However, please bear in mind that any early drafts that you retain in your file will be subject to disclosure and you may be cross-examined on them.

Trial Dates & Procedural Matters

The trial of this case has been scheduled for November 18 – December 13, 2019 in Vancouver, British Columbia. You may be required to attend cross examination and, if so, we will do our best to work within the constraints of your existing schedule and obligations.

We look forward to receiving your report on or before **February 28, 2019**.

Please do not hesitate to contact me at 604-666-4304 if you require further information or have any questions regarding the foregoing.

Yours truly,

BJ Wray
Senior Counsel

Enclosures: Affidavit of Dr. Dembo, dated December 14, 2018; Affidavit #2 of Ms. Julia Lamb, dated December 13, 2018

Appendix 2

Curriculum Vitae

Madeline Li, MD, PhD, FRCP(C)

A. Date Curriculum Vitae is Prepared: February 22, 2019

B. Biographical Information

Primary Office	Princess Margaret Hospital 16-749, 610 University Avenue Toronto, Ontario, Canada M5G 2M9
Telephone	416-946-4501 x7505
Fax	416-946-2047
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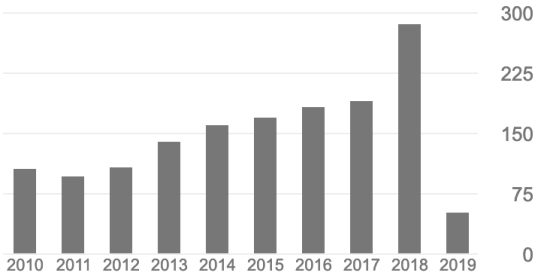
1. CITATIONS (Orcid ID: 0000-0002-3977-7437)



Citation Indices	All	Since 2014
Citations	2200	1047
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i10-index	39	33

2. EDUCATION

Degrees

1989 - 1999	MD, University of Toronto, Toronto, Ontario, Canada (MD PhD programme)
1991 - 1997	PhD, Department of Medical Biophysics, University of Toronto, Toronto, Ontario, Canada *Thesis: Mechanisms of gene regulation in the undifferentiated intestinal epithelium* Supervisor: Dr. Ronald Buick

1984 -1988	BSc, Molecular Genetics & Molecular Biology (Hons), University of Toronto, Toronto, Ontario, Canada

Postgraduate, Research and Specialty Training

2005 - 2007	Clinical Fellowship in Cancer Psychiatry, Psychosocial Oncology & Palliative Care, Department of Psychiatry, University of Toronto *Part-time research project: Psychoneuroimmunology and genetics of depression in cancer patients* Supervisor(s): Drs. Gary Rodin & Christopher Paige
1999 - 2005	Residency, Psychiatry, Faculty of Medicine, University of Toronto
1997 May – 1997 Aug	Postdoctoral Fellow, Dept of Medical Genetics, The Hospital for Sick Children (volunteered during medical training 1997-2000) *Research project: Epigenetic imprinting in childhood overgrowth and tumour predisposition syndromes* Supervisor(s): Drs. Rosanna Weksberg & Jeremy Squire
1987 - 1989	Summer Student & Honours Research, Ontario Cancer Institute *Research project: Cloning hamster DNA mismatch repair genes* Supervisor: Dr. Gordon Whitmore

Qualifications, Certifications and Licenses

2005 - present	Fellow, Psychiatry, Royal College of Physicians and Surgeons of Canada License / Membership #: 647360
2005 - present	Psychiatry, College of Physicians and Surgeons of Ontario License / Membership #: CPSO # 73839

3. EMPLOYMENT

Current Appointments

2018 – present	Scientist, Princess Margaret Cancer Centre Research Institute, Toronto, Ontario, Canada
2017 – present	Associate Member, Institute of Medical Science, University of Toronto, Toronto, Ontario, Canada
2017 – present	Associate Professor, Psychiatry, University of Toronto, Toronto, Ontario, Canada
2007 - present	Staff Psychiatrist, Dept of Psychiatry, University Health Network, Toronto, Ontario, Canada

2005 – present	Researcher, Dept of Supportive Care, Princess Margaret Hospital, Toronto, Ontario, Canada.

Previous Appointments

CLINICAL

2012 Apr - 2013 Sep	Psychosocial Oncology Regional Clinical Lead, Toronto South-Central LHIN, Cancer Care Ontario, Ontario, Canada

HOSPITAL

1986 Aug - 1987 Sep	Medical Autopsy Dicta-Typist, Coroner's Office & Dept of Pathology, Toronto General Hospital, Toronto, Ontario, Canada

RESEARCH

1988 May - 1988 Sep	Research Assistant, Microbiology and Immunology, Queen's University at Kingston, Ontario, Canada

UNIVERSITY

2007 - 2017	Assistant Professor, Psychiatry, University of Toronto, Toronto, Ontario, Canada
1997	Graduate Course Instructor, Dept of Anatomy, University of Toronto, Toronto, Ontario, Canada

WORK INTERRUPTIONS

2001 Sep - 2002 Aug	*Maternity leave*
1999 Oct - 2000 Feb	*Maternity leave*

4. HONOURS AND CAREER AWARDS

Distinctions and Research Awards

LOCAL

2018 - 2023 **Academic Scholars Award**
Department of Psychiatry, University of Toronto

To support professional research development of early-career and mid-career faculty members to progress towards attaining academic promotion

2013 **Don Wasylenki Award for Social Responsibility**, Department of Psychiatry, University of Toronto.

For teamwork in consultancy to develop a Psychosocial Oncology and Palliative Care program in the Kuwait Cancer Control Centre

Student/Trainee Awards

NATIONAL

2005 - 2007	**Research Fellowship Award**, Canadian Institutes of Health Research. (Research Award)
1990 - 1992	**Studentship**, Medical Research Council of Canada. (Research Award)

PROVINCIAL / REGIONAL

1994 - 1995	**Ontario Graduate Scholarship**, Government of Ontario. (Distinction)
1984	**Ontario Scholar**, Government of Ontario. (Distinction)

LOCAL

2006	**Research Fellowship Award**, Weekend to End Breast Cancer (WEBC). (Research Award)
1998	**Tweedie Cancer Bursary**, University of Toronto. (Distinction)
1995	**George Brown Memorial Award for Research Accomplishment**, University of Toronto. (Distinction)
1994 - 1995	**Medical Student Research Day - 2nd prize**, University of Toronto. (Distinction)
1993	**George Brown Memorial Award for Research Accomplishment**, University of Toronto. (Distinction)
1988 - 1989	**Samuel Castrilli Award**, University of Toronto, Faculty of Medicine. (Distinction)
1986 - 1987	**G. W. Billes Open Admission Scholarship**, University of Toronto. (Distinction)
1984	**G. W. Billes Open Admission Scholarship**, University of Toronto. (Distinction)
1984	**Head Girl**, Parkdale Collegiate Institute, Graduating Class. (Distinction)

5. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

2014 - present	International Psychosocial Oncology Society (IPOS)
2005 - present	Canadian Association for Psychosocial Oncology (CAPO)
2005 - present	Psychoneuroimmunology Research Society (PNIRS)
1999 - present	Canadian Psychiatric Association (CPA)
1999 - present	Ontario Psychiatric Association (OPA)
1988 - present	Canadian Medical Association (CMA)

1988 - present Ontario Medical Association (OMA)

Administrative Activities

NATIONAL

Canadian Partnership Against Cancer

2010 - 2012 **Member**, Screening for Distress Implementation Group, Cancer Journey Action Group

2010 **Princess Margaret Representative**, CancerChatCanada Workshop, Cancer Journey Action Group

PROVINCIAL / REGIONAL

Cancer Care Ontario

2012 - present **Member**, Provincial Psychosocial Oncology (PSO) Committee

2012 – 2013 **Psychosocial Oncology Clinical Lead**, Toronto South Central LHIN

2013 **Member**, Psychosocial Oncology Wait Times Expert Panel, PSO Committee

2013 **Member**, Psychosocial Oncology Quality Indicators Working Group, PSO Committee

2013 **Clinical Lead**, Anxiety and Depression PROMs Working Group, PSO Committee

LOCAL

Other Organizations

2012 – present **Inaugural Chair and Member**, Toronto Central LHIN Psychosocial Oncology Working Group

Ontario Cancer Institute

2008 - 2009 **Member**, Research Seminar Committee

University Health Network

2016 - present **Program Lead**, University Health Network Medical Assistance in Dying (MAID)

Princess Margaret Cancer Centre

2016 - present **Lead**, Psychosocial Oncology Service, Department of Supportive Care

2016 - present **Chair**, New Models of Care Working Group to create collaborative psychosocial oncology care models in line with the departmental strategic plan

2015 - present	**Psychosocial Oncology Member**, Supportive Care Executive Committee
2013 - present	**Member**, Head and Neck Survivorship Steering Committee
2012 - 2014	**Psychosocial Oncology Clinical Lead member**, Toronto-Central Regional Cancer Program Steering Committee
2007 - present	**Developer and Physician Lead**, Distress Assessment and Response Tool Program (DART)

Peer Review Activities

GRANT REVIEWS

Reviewer

2016	CIHR 1st Live Pilot competition - Stage 1 Project Scheme Committee
2010 - 2013	Head and Neck Cancer Translational Research Program IDEAS Grant Competition, Number of Reviews: 10
2008 - 2010	Department of Psychiatry, University Health Network, Research Strategy Committee, Number of Reviews: 6

MANUSCRIPT REVIEWS

Guest Editor

2018	International Journal of Methods in Psychiatric Research: 1

Reviewer

2010 - present	Psycho-Oncology, Number of Reviews: 19
2011 - present	Supportive Care in Cancer, Number of Reviews: 4
2018	New England Journal of Medicine, Number of Reviews: 1
2017	Palliative Medicine, Number of Reviews: 1
2015	Journal of Global Oncology, Number of Reviews: 1
2014	Annals of Medicine, Number of Reviews: 1
2014	BMC Cancer, Number of Reviews: 2
2014	Journal of Cancer Survivorship, Number of Reviews: 1
2013	Annals of Oncology, Number of Reviews: 1
2013	Biological Psychology, Number of Reviews: 1
2012	Drugs, Number of Reviews: 1
2011	Assessment, Number of Reviews: 1
2006 - 2010	Journal of Psychosomatic Research, Number of Reviews: 7

Other Research and Professional Activities

2017 – 2018	**Expert Panel Reviewer**. Recommendations for the Delivery of Psychosocial Oncology Service in Ontario. Cancer Care Ontario.
2017 – 2018	**Member**. Planning Committee for the 2018 Canadian Association of Psychosocial Oncology Annual Meeting
2012 - present	**Collaborator**. Canadian Biomarker Integration Network in Depression (CAN-BIND). Ontario Brain Institute funded multi-site study. Collaborator(s): Principal Investigator: Dr. S. Kennedy.
2014 - 2015	**Member**. Pan-Canadian Psychosocial Distress Symptom Management Guideline. Canadian Association of Psychosocial Oncology.
2013 - 2014	**Chair**. Management of Depression in Cancer Guidelines Working Group. Program in Evidence Based Care, Cancer Care Ontario.
2013 - 2014	**Advisor**. Economic Analysis of Psychosocial Oncology Services and Health Care. Cancer Care Ontario.
2009 - 2010	**Member**, Psychosocial Oncology Framework Guidelines Committee, Program in Evidence-Based Care, Cancer Care Ontario

C. Academic Profile

1. RESEARCH STATEMENT

Independent and collaborative research in psychosocial variables and biomarkers associated with behavioural symptoms in cancer patients. My research goal is to develop a research program exploring the biological contributions to psychological distress in cancer patients. A multi-disciplinary approach combining psychoneuroimmunology, genetics and psychosocial oncology research is central to this research. This research program requires establishing connections between basic laboratory sciences and psychosocial research departments, fostering collaborations within research divisions, and advocacy to promote awareness of the health outcome impact of psychiatric illness in medical conditions.

2. TEACHING PHILOSOPHY

My core belief in psychiatric education is to teach health care providers to fully integrate biological and psychological perspectives in understanding the patient experience of illness and delivering truly bio-psycho-socially informed care. Teaching at the undergraduate, post-graduate and continuing professional education levels has been focused on shifting cancer care from a tumour-centred, towards a person-centred model of care.

3. CREATIVE PROFESSIONAL ACTIVITIES STATEMENT

My vision is to improve the quality of psychosocial oncology care delivered to cancer patients. This involves expanding the capacity of the health care system to provide psychosocial oncology care by improving the evidence base for emotional distress screening using patient reported outcomes (PRO) in cancer, as well as inter-professional engagement in the delivery of psychosocial care. The long-term goal is knowledge translation for using PRO data to improve patient health outcomes and as person-centred co-variates in biological research studies.

D. Research Funding

1. GRANTS, CONTRACTS AND CLINICAL TRIALS

PEER-REVIEWED GRANTS

FUNDED

2018 Oct – Sept 2023 **Co-Principal Investigator.** *The Longitudinal Study of Medical Assistance in Dying (MAiD) in Patients with Advanced Canc*er. CIHR Project Grant. PI: **M. Li**, G. Rodin. Co-investigators: J. Bell, C. Graham, S. Hales, R. Nissim, G. Shapiro, R. Wong, C. Zimmermann. 818,550 CAD
Study of the prevalence, predictors and patient attitudes about MAiD, and changes in the prevalence of desire for hastened death over the past decade

2018 Apr – 2018 May **Co-Investigator**. *Canadian Association of Psychosocial Oncology (CAPO) 2018: Tailored and Targeted Interventions - The New Psychosocial Frontier. CIHR Planning and Dissemination Grant – Institute Community Support*. Howell, D. Moody, L., Devins, G., **Li, M**., Rodin, G., Laycock, A. $10,000 CAD.
Knowledge translation funding for the CAPO annual conference.

2018 Feb – 2021 Jan **Co-Investigator.** *Medical Assistance in Dying (MAID) in the cancer context: a mixed methods study of patient and caregiver experience, quality of death, and bereavement morbidity. CCSRI Quality of Life Research Grant. PI: S. Hales, R. Nissim. Co-investigators: M. Li, G. Rodin, J. Bell, S. Bean, E. Isenberg-Grzeda, D. Selby. 297,827 CAD*
Study of the impact of MAiD on the quality of death and dying and bereavement in patients and their caregivers.

2017 Apr - 2022 Mar **Co-Investigator**. *Symptom screening and early palliative care in patients with advanced cancer: a randomized trial.* Canadian Institutes of Health Research. Project Grant. PI; Zimmermann,

Camilla. Collaborator(s): Booth, Christopher M; Dudgeon, Deborah; Hannon, Breffni; Howell, Doris M; Krzyzanowska, Monika K; Leighl, Natasha B; **Li, Madeline**; Rodin, Gary M; Rydall, Anne C; Sridhar, Srikala S; Viola, Raymond A. 1,002,150 CAD
Clinical trial of patient reported outcome triggered referral in palliative care

2017 Apr - 2019 Mar **Co-Investigator**. *Symptom screening with targeted early palliative care (STEP) for patients with advanced cancer: a pilot trial*. Ontario Academic Health Science Alternate Funding Plan, Ministry of Health and Long-Term Care and Ontario Medical Association. MSH UHN AMO Innovation Fund Competion. PI: Zimmermann, Camilla. Collaborator(s): Warr, David; Krzyzanowska, Monika; Knox, Jennifer; Oza, Amit; Leighl, Natasha; Sridhar, Srikala; Rodin, Dr. Gary; **Li, Madeline**; Lo, Christopher; Hannon, Breffni; Howell, Doris. 183,394 CAD
Pilot study of patient reported outcome triggered referral in palliative care

2017 Feb – 2019 Jan **Principal Investigator**. *Intranasal ketamine for depression in patients with cancer receiving palliative care: a phase II, open-label clinical trial. CCSRI Quality of Life Research Grant. PI: M. Li. Co-investigators: C. Lo, J. Rosenblat, C. Zimmermann, R. McIntyre, B. Hannon, G. Rodin, J. Bryson, K. DeBuono. 154,155 CAD*
A phase II, open-label clinical trial of ketamine for depression in patients with cancer at the end of life

2016 Jul - 2018 Jun **Co-Investigator**. Implementation of Distress Assessment and Response Tool (DART) screening program in Kuwait Cancer Control Center (KCCC). Kuwait Foundation for the Advancement of Sciences (KFAS). PI: M. Al Awadhi. Collaborator(s): H. Abdul Karim, A. Hamadah, S. Alkhadari, Y. Leung, **M. Li**, G. Rodin. 409,653 CAD.
International expansion of DART and implementation of the first distress screening program in the Middle East.

2016 Feb - 2019 Jan **Co-Investigator**. Effectiveness of a telephone-supported depression self-care intervention for cancer survivors. Canadian Cancer Society Research Institute (CCSRI). PI: J. McCusker. Collaborator(s): M. Yaffe, R. Faria, A. Ciampi, S. Lambert, **M. Li**, J. Jones. 299,929 CAD.
Multi-site randomized clinical trial of the Depression Intervention via Referral, Education and Collaborative Treatment – Self Care (DIRECT-SC) intervention for depression in cancer survivors.

2015 Aug - 2017 Jul **Co-Principal Investigator**. Cytokines and Symptom Clusters: A Machine Learning Approach to Identifying Intervention Targets. Collaborative Personalized Cancer Medicine Team Grant. PI: **M. Li**, B. Haibe-Kains. Collaborator(s): G. Rodin, S. Ferguson, H. Mackay, C. Paige. 300,000 CAD.
Use of machine learning to identify biologically informed symptom clusters based on plasma cytokine profiles and distress screening data in ovarian cancer patients.

2015 Apr - 2019 Sep **Co-Investigator**. Prostate Cancer 360 Degrees. Prostate Cancer Canada. PI: J. Jones, A. Matthew, L. Goldenberg, S. Tanguay. Collaborator(s): A. So, A. Aprikian, D. Santa Mina, D. Elterman, D. Howell, **M. Li**, M. Gleave, M. Krahn, N. Fleshner, P. Warde, P. Black, P. Chung, R. Hamilton, S. Alibhai, S. Elliot, W. Kassouf, Z. Rosberger. 1,218,025 CAD.
Establishment of a standardized patient reported outcomes measurement system and randomized controlled trial of its use in survivorship care plans for prostate cancer patients.

2014 Jan - 2017 Jan **Co-Principal Investigator**. Improving Patient Experience and Health Outcomes Collaborative (iPEHOC). Canadian Partnership Against Cancer. PI: **M. Li** and D. Howell. Collaborator(s): E. Green, A. Lynch, C. Mayer, M. Rugg, A. Kewayosh, Z. Rosberger, M. Hamel, R. Faria. 1,025,000 CAD. *Multi-site implementation project evaluating the clinical utility and health outcomes impact of routine collection of patient reported outcome measures for anxiety, depression, pain and fatigue in cancer patients*.

2012 Jan - 2015 Dec **Co-Investigator**. The relationship between local breast radiation and hematopoietic stem cell trafficking and fatigue. Canadian Breast Cancer Foundation (CBCF). PI: FF Liu. Collaborator(s): **M. Li**, P. Catton, A. Fyles, M. Gospodarowicz, M Minden, R. Sutherland, W. Xu. 449,577 CAD.
Biomarker study of correlates of fatigue and stem cell trafficking in breast cancer patients undergoing breast radiation.

2011 Jul - 2016 Jul **Co-Principal Applicant**. On-PROST: Ontario Patient Reported Outcomes of Symptoms and Toxicity. Cancer Care Ontario. PI: D. Howell, G. Liu, M. Brundage, A. Hope, G. Rodin, L. Ba. 1,182,500 CAD.
To develop generic, disease and research-specific patient reported outcome measures and pilot test them using computer adaptive technology to improve the patient experience of cancer and research infrastructure.

2010 Sep - 2015 Aug **Co-Investigator**. Managing Cancer and Living Meaningfully: An RCT of a Psychotherapeutic Intervention for Patients with Metastatic Cancer. Canadian Institutes of Health Research (CIHR). PI: G. Rodin & S. Hales (Co-PIs). Collaborator(s): A. Donner, L. Gagliese, P. Kurdyak, **M. Li**, C. Lo, M. Moore, R. Nissim, A. Rydall, C. Zimmermann. 1,459,441 CAD.
Randomized controlled trial of a brief psychotherapy delivered by non-psychiatric specialists to reduce emotional distress in cancer patients with palliative stage disease.

2010 Jul - 2011 Dec **Principal Investigator**. Distress Assessment and Response Tool (DART). Canadian Partnership Against Cancer. Collaborator(s): G. Rodin. 125,000 CAD.
To study best practice implementation methods for screening for distress in cancer.

2008 Apr - 2011 Mar **Co-Investigator**. A comprehensive study of quality of life and fatigue in AML. Canadian Institutes of Health Research (CIHR). PI: S. Alibhai. Collaborator(s): J. Brandwein, R. Buckstein, V. Gupta, **M. Li**, M Minden, G. Tomlinson. 322,500 CAD.
Study of an exercise intervention and biomarkers predictive of quality of life and fatigue in patients with acute myeloid leukemia.

2007 Apr - 2012 Mar **Co-Investigator**. Age-related patterns in pain following breast cancer surgery. Canadian Breast Cancer Research Alliance. PI: L. Gagliese. Collaborator(s): G. Rodin, G. Koren, V. Chan, **M. Li**. 747,490 CAD.
Study of medical, psychosocial and biomarker variables contributing to persistent pain in breast cancer patients.

2006 **Principal Investigator**. Etiology of depression in cancer: psychoneuroimmunology and genetics. University of Toronto. Dept of Psychiatry Grant Competition. Collaborator(s): G. Rodin. 5,000 CAD.
Characterization of cytokine profiles and genetic vulnerability to depression in cancer patients.

2001 **Co-Author**. Genomic imprinting in a tumor predisposing region of chr band 11p15. National Cancer Institute of Canada (NCIC). PI: R. Weksberg. Collaborator(s): J. Squire, **M. Li**. 58,879 CAD.
Characterization of allele-specific methylation and replication timing of the IGF2 and H19 genes in Beckwith-Wiedemann syndrome.

1997 - 2000 **Co-Author**. Genomic imprinting in a tumor predisposing region of chr band 11p15. National Cancer Institute of Canada (NCIC). PI: R. Weksberg. Collaborator(s): J. Squire, **M. Li**. 354,854 CAD.

Characterization of genomic imprints in childhood overgrowth syndromes.

E. Publications

1. MOST SIGNIFICANT PUBLICATIONS

1. **M. Li**, S. Watt, M. Escaf, M. Gardam, A. Heesters, G. O'Leary, G. Rodin. From Legislation to Implementation: A Hospital-Based Program of Medical Assistance in Dying. New Eng J Med., 376:2082-2088, 2017. Impact Factor: 72.4.

   Successful development and implementation of a euthansia program in a large urban institutional setting, which balances the rights of patients with attention to protection of interests of vulnerable patients and staff.

2. **M. Li**, A. Macedo, S. Crawford, S. Bagha, Y. Leung, C. Zimmermann, B. Fitzgerald, M. Wyatt, T. Stuart-McEwan, G. Rodin. Easier Said Than Done: Keys to Successful Implementation of the Distress Assessment and Response Tool (DART) Program. J Oncol Pract. 12:e513-e526, 2016. Impact Factor: N/A.

   Lessons learned and evidence of clinical impact from DART, the largest successful emotional distress screening program in Canada.

3. **M. Li**, E. Kouzmina, D. Rodin, P.C. Boutros, C.J. Paige, G. Rodin. Pro- and anti-inflammatory cytokine associations with major depression in cancer patients. Psycho-Oncology. 2016 DOI: 10.1002/pon.4316. Impact Factor: 3.1.

   Demonstration on naturalistic cytokine assocations with depression and sickness behaviours in cancer patients as potential targets of novel pharmacotherapies.

4. **M. Li**, E.B. Kennedy, N. Bryne, C. Gerin-Lajoie, E. Green, M.R. Katz, H. Keshavarz, S.M. Sellick. The Management of Depression in Patients with Cancer. The Management of Depression in Patients with Cancer; 2015 May. Available from: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=340750. Impact Factor: N/A.

   Practice guideline based on a systematic review and meta-analysis of pharmacologic and psychologic treatment for depression in patients with cancer.

5. **M. Li**, P. Fitzgerald, G. Rodin. Evidence-Based Treatment of Depression in Patients with Cancer. J Clin Oncol. 30:1187-1196, 2012. Impact Factor: 20.98.

   Narrative literature review and practical guidance for the treatment of depression in cancer patients.

2. PEER-REVIEWED PUBLICATIONS

Journal Articles

1. J.D. Rosenblat, A.F. Carvalho, **M. Li**, Y. Lee, M. Subramanieapillai, R.S. McIntyre. Oral Ketamine for Depression: A Systematic Review. J Clinical Psychiatry, in press.

2. M. Moskovitz, K. Jao, C.M. Brown, J. Su, H. Naik, L. Eng, T. Wang, Y. Leung, W. Xu, L. Barbera, G. Devins, L. Moody, N. Mittmann, **M. Li**, D. Howell, G. Liu. Combined cancer patient reported symptom and health utility tool for routine clinical implementation: A real world comparison of ESAS and EQ5D across multiple cancer sites. European Journal Of Cancer, in press.

3. D.E. Stewart, G. Rodin, M. Li. Consultation-liason psychiatry and physician-assisted death. General Hospital Psychiatry 55:15-19, 2018.

4. E. Hall, E. Tam, M. Liang, Q. Zhang, L. Liu, L. Wong, S. Sarabia, S. Yeung, G. Gill, L. Eng, A. Perez-Cosio, M.C. Brown, W. Xu, **M. Li**, N. Mittmann, J. Jones, D.M. Howell, G. Liu. **Development and prospective evaluation of CAPLET, a cancer ambulatory patient physical function longitudinal evaluation tool for routine clinical practice. Supportive Care in Cancer,** 2019 Feb;27(2):521-530

5. **M. Li**, C. Sanders, C.-H. Lee, A. Macedo, S. Molloy, S. Laframboise, Y.W. Leung. Symptom Screening for Constipation in Oncology: Getting to the Bottom of the Matter. Supportive Care in Cancer, 2018, Oct 30. doi: 10.1007/s00520-018-4520-7.

6. E. Tang, O. Ekundayo, J. D. Peipert, N. Edwards, A. Bansal, S. J. Bartlett, D. Howell, **M. Li**, M. Novak, I. Mucsi. Validation of the Patient Reported Outcomes Measurement Information System (PROMIS) -57 and -29 Item Short Forms among Kidney Transplant Recipients. Quality of Life Research, 2018, Nov 22. doi: 10.1007/s11136-018-2058-2.

7. S. El-Majzoub, I. Mucsi, **M. Li**, G. Moussaoui, K.J. Looper, M. Novak, S. Rej. Psychosocial Distress and Health Service Utilization in Patients Undergoing Dialysis: A Prospective Study. Psychosomatics, 2018 Oct 10. pii: S0033-3182(18)30466-3.

8. A.M. Sawka, S. Watt, G. Rodin, S. Ezzat, D. Howell, R.W. Tsang, J.D. Brierley, M.K. Krzyzanowska, D. Goldstein, **M. Li**. Symptom Burden in Adults with Thyroid Cancer: A Cross-sectional Analysis from Princess Margaret Cancer Centre. Psycho-Oncology, 27 (10):2517-2519, 2018.

9. G. Rodin, C. Lo, A, Rydall, J. Shnall, C. Malfitano, A. Chiu, T. Panday, S. Watt, E. An, R. Nissim, **M. Li**, C. Zimmermann, S. Hales. Managing Cancer And Living Meaningfully: A Randomised Controlled Trial of a Psychological Intervention for Patients with Advanced Cancer. JCO 2018, Aug 10:36(23):2422-2432

10. **M. Li**, D. Kaine. The other side of sorrow: physician reflections on assisted dying. CMAJ, 190(6):E169-E170, 2018

11. D. Wong, S. Cao, H. Ford, C. Richardson, D. Belenko, E. Tang, L. Ugenti, E. Warsmann, A. Sissons, Y. Kulandaivelu, N. Edwards, M. Novak, **M. Li**, I. Mucsi. Exploring the use of tablet computer-based electronic data capture system to assess patient reported measures among patients with chronic kidney disease: a pilot study. BMC nephrology, 18:356, 2017

12. L. Grassi, M.G. Nanni, G. Rodin, **M. Li,** R. Caruso. Practical tips on antidepressant usage for oncologists. Annals of Oncology, 2017 doi:10.1093/annonc/mdx526

13. **M. Li**, E. Kouzmina, D. Rodin, P.C. Boutros, C.J. Paige, G. Rodin. Cytokines and depression in cancer patients and caregivers. Neuropsych Dis and Treat, 13:2903, 2017.

14. J. McCusker, M. Yaffe, R. Faria, S. Lambert, **M. Li**, J. Poirier-Bisson, M. Magalhaes, M. de Raad. Phase II trial of a depression self-care intervention for adult cancer survivors. European Journal of Cancer Care, 2017. DOI 10.1111/ecc.12763

15. J.K. Soczynska, S.H. Kennedy, M. Alsuwaidan, R. Mansur, **M. Li,** M.P. McAndrews, E. Brietzke, V. Taylor, R.S. McIntyre. A Pilot, Open-label, 8-Week Study Evaluating the Efficacy, Safety and Tolerability of Adjunctive Minocycline for the Treatment of Bipolar I/II Depression. Bipolar Dis., 19:198-213, 2017.

16. **M. Li**, G. Rodin. Medical Assistance in Dying - Reply. New Engl J Med. 377:897, 2017.

17. **M. Li**, S. Watt, M. Escaf, M. Gardam, A. Heesters, G. O'Leary, G. Rodin. From Legislation to Implementation: A Hospital-Based Program of Medical Assistance in Dying. New Eng J Med., 376:2082-2088, 2017.

18. **M. Li**, E.B. Kennedy, N. Byrne, C. Gerin-Lajoie, M.R. Katz, H. Keshavarz, S. Sellick, E. Green. Systematic Review and Meta-analysis of Collaborative Care Interventions for Depression in Patients with Cancer. Psycho-Oncology. 26:573-587, 2017.

19. **M. Li**, E. Kouzmina, D. Rodin, P.C. Boutros, C.J. Paige, G. Rodin. Pro- and anti-inflammatory cytokine associations with major depression in cancer patients. Psycho-Oncology. 2016 DOI: 10.1002/pon.4316.

20. **M. Li**, A. Macedo, S. Crawford, S. Bagha, Y. Leung, C. Zimmermann, B. Fitzgerald, M. Wyatt, T. Stuart-McEwan, G. Rodin. Easier Said Than Done: Keys to Successful Implementation of the Distress Assessment and Response Tool (DART) Program. J Oncol Pract. 12:e513-26, 2016.

21. C. Lo, S. Hales, A. Rydall, T. Panday, A. Chiu, C. Malfitano, J. Jung, **M. Li**, R. Nissim, C. Zimmermann, G. Rodin. Managing Cancer and Living Meaningfully (CALM): randomized feasibility trial in patients with advanced cancer. BMJ Support Palliat Care. 2016 Jan 19. pii: bmjspcare-2015-000866. doi: 10.1136/bmjspcare-2015-000866. [Epub ahead of print].

22. **M. Li**, E.B. Kennedy, N. Byrne, C. Gerin-Lajoie, M.R. Katz, H. Keshavarz, S. Sellick, E. Green. Management of Depression in Patients with Cancer: A Clinical Practice Guideline. J Onc Practice. 12(8):747-56, 2016.

23. C. Lo, S. Hales, A. Rydall, T. Panday, A. Chiu, C. Malfitano, J. Jung, **M. Li**, R. Nissim, C. Zimmermann, G. Rodin. Managing Cancer and Living Meaningfully: study protocol for a randomized controlled trial. Trails.16:391, 2015

24. P. Fitzgerald, **M. Li**, L. Gagliese, C. Zimmermann, G. Rodin. The Relationship between Depression and Physical Symptom Burden in Advanced Cancer. BMJ Supportive & Palliative Care. 5:381-388, 2015.

25. S.M.H. Alibhai, H. Breunis, N. Timilshina, R. Brignardello-Petersen, G. Tomlinson, H. Mohamedali, V. Gupta, M.D. Minden, **M. Li**, R. Buckstein, J.M. Brandwein. Quality of life and physical function in adults treated with intensive chemotherapy for acute myeloid leukemia improve over time independent of age. J Geriatric Oncology. 6:262-271, 2015.

26. N. Timilshina, H. Breunis, J.M. Brandwein, M.D. Minden, V. Gupta, S. O'Neil, G. Tomlinson, R. Buckstein, **M. Li**, S.M.H. Alibhai. Do quality of life or physical function at diagnosis predict short-term outcomes during intensive chemotherapy in AML? Annals of Oncology. 25:883-888, 2014.

27. Y. Leung, **M. Li**, G. Devins, C. Zimmermann, C. Lo, G. Rodin. Routine Screening for Suicidal Intention in Patients with Cancer. Psycho-Oncology. 22:2537-2545, 2013.

28. F. Fung, **M. Li**, H. Breunis, N. Timilshina, SMH Alibhai. Correlations between cytokine levels and changes in fatigue and quality of life in patients with acute myeloid leukemia. Leukemia Research. 37:274-279, 2013.

29. S. Bagha, A. Macedo, L. Bishop, G. Rodin, **M. Li**. The utility of the Edmonton Symptom Assessment System in screening for anxiety and depression. Eur J Cancer Care (Engl). 22:60-69, 2013.

30. **M. Li**, E. Green. The Ontario Psychosocial Oncology Framework: A Quality Improvement Tool. Psycho-Oncology. 22:1117-1179, 2013.

31. **M. Li**, P. Fitzgerald, G. Rodin. Evidence-Based Treatment of Depression in Patients with Cancer. J Clin Oncol. 30:1187-1196, 2012.

32. H. Mohamedali, H. Breunis, N. Timilshina, J. Brandwein, V. Gupta, **M. Li**, G. Tomlinson, R. Buckstein, SMH Alibhai. Older age is associated with similar quality of life and physical function compared to younger age during intensive chemotherapy for acute myeloid leukemia. Leukemia Research.36:1241-1248, 2012.

33. R. Li, J. Hou, Q. Xu, QJ. Liu, YJ. Shen, G. Rodin, **M. Li**. High level interleukin-6 in themedium of human pancreatic cancer cell culture suppresses production of neurotransmitters by PC12 cell line. Metab Brain Dis. 27:91-100, 2012.

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37. C. Lo, C. Zimmermann, L. Gagliese, **M. Li**, G. Rodin. Sources of spiritual well-being in patients with advanced cancer. BMJ Supportive and Palliative Care. 1:149-153, 2011.

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40. C. Lo, **M. Li**, G. Rodin. The assessment and treatment of distress in cancer patients: overview and future directions. Minerva Psychiatry. 49:129-143, 2008.

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57. A.M. Dulhanty, **M. Li**, G.F. Whitmore. Isolation of Chinese hamster ovary cell mutants deficient in excision repair and mitomycin C bioactivation. Cancer Research.49:117-122, 1989.

Book Chapters

1. **M. Li,** T. Balboni, R. Nissim, G. Rodin. Validated assessment tools for psychological, spiritual, and family issues. In: Nathan Cherny, Marie Fallon, Stein Kaasa, Russell K. Portenoy, and David C. Currow, editors, Oxford Textbook of Palliative Medicine. Oxford University Press (OUP); in preparation, 2020.

2. **M. Li**, J. Rosenblat, G. Rodin. Depression. In: James L. Levenson, Lawson Wulsin, editors. Textbook of Psychosomatic Medicine and Consultation-Liason Psychiatry. Arlington (United States): American Psychiatric Publishing; in press, 2018.

3. **M. Li**, J. Rosenblat, G. Rodin. Pharmacologic management of depression and anxiety in patients with cancer. In: Maggie Watson, David Kissane, editor(s). Management of Clinical Depression and Anxiety: Companion Guides for Clinicians. Oxford University Press; 2017. p 78

4. **M. Li**, S. Hales, G. Rodin. Section VIII, Chapter 39. Adjustment Disorders. In: Jimmie C. Holland, William S. Breitbart, Paul B. Jacobsen, Marguerite S. Lederburg, Matthew J. Loscalzo, Ruth McCorkle, editor(s). Psycho-Oncology. 3rd ed. New York (United States): Oxford University Press; 2015. p. 274-280.

5. P. Fitzgerald, **M. Li**, K. Miller, G. Rodin. Section VIII, Chapter 41. Depression. In: Jimmie C. Holland, William S. Breitbart, Paul B. Jacobsen, Marguerite S. Lederburg, Matthew J. Loscalzo, Ruth McCorkle, editor(s). Psycho-Oncology. 3rd ed. New York (United States): Oxford University Press; 2015. p. 281-288.

6. Fitzgerald, P., **M. Li**, Rodin, G. Pharmacotherapy of Depression in Cancer Patients. In: Luigi Grassi, Michelle Riba, editor(s). Psychopharmacology in Oncology and Palliative Care – a Practical Manual. Springer eBooks; 2014. p. 145-162.

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8. **M. Li**, G. Rodin. Chapter 11. Altruism and Suffering in the Context of Cancer: Implications of a Relational Paradigm. In: B. Oakley, A. Knafo, G. Madhavan, D. Sloan Wilson, editor(s). Pathological Altruism. New York (United States): Oxford University Press; 2011. p. 138-155.

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11. **M. Li**, G. Rodin. Chapter 14. Depression and Illness. In: Jerry M. Suls, Karina W. Davidson, Robert M. Kaplan, editor(s). Handbook of Health Psychology and Behavioral Medicine. New York (United States): Guilford Press; 2010. p. 217-234.

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In Preparation

1. S.M.H. Alibhai, H. Breunis, J. Matelski, M.D. Minden, N. Timilshina, A. Kundra, **M. Li.** Do Pre-Induction Cytokine Levels Improve Prediction of Achieving Complete Remission After Induction Cheotherapy in Adults with Acute Myeloid Leukemia.

2. **M. Li**, G. Rodin. A Brave New World: Personal and Professional Reflections on Assisted Dying.

3. **M. Li**, M. McCusker, A. Kundra, B. Haibe-Kains, R. Bazinet. Free fatty acids and major depression in cancer patients.

4. **M. Li**, B. Gascon, J. Elman, A. Macedo, LG. Rodin. Validation of a Two-Step Probabilities Approach for Depression and Anxiety Screening using the Distress Assessment and Response Tool (DART).

5. A. Kundra, L. McColl, Y. Leung, A. Macedo, G. Rodin, **M. Li**. Impact of the Distress Assessment and Response Tool (DART) program on patient health outcomes.

6. C. Sade, A. Twiddy, A. Macedo, M. Wyatt, C. Zimmermann, G. Rodin, **M. Li**. Longitudinal Trends in Screening for Distress scores: Predictors of Persistence and Uptake of Psychosocial Services.

7. Y. Klein, **M. Li**, H. Panet, L. Mitchell, T. Stuart-McEwan, A. Macedo, M. Maganti, A.A. Gupta, N.M. D'Agostino. An Examination of Predictors of Distress and Well Being Among Adolescent and Young Adult Cancer Patients in a Large Canadian Comprehensive Cancer Center.

Clinical Care Guidelines

14. D. Howell, K.G. Wilson, M. Li, H. Chochinov, E. Wasylenko, J. Bell, J. Rivest, C. Hammond. Role of Psychosocial Oncology in Medical Assistance in Dying (MAID). Canadian Assocation of Psychosocial Oncology Position Statement. Sept 12, 2017. Available from: https://oncology.capo.ca/public/capo-newsfeed/capos-position-statement-role-psychosocial-oncology-medical-assistance-dying/

15. S.R. Black, A. Pringle, K.R. Bilger, M. Li. Canadian Association for Music Therapists' Postion Statement on MAiD (Medical Assistance in Dying). Canadian Association of Music Therapists. March 2017. Available from: https://www.musictherapy.ca/wp-content/uploads/2017/03/CAMT-MAiD-Statement.pdf

16. D. Howell, H. Keshavarz, M.J. Esplen, T. Hack, M. Hamel, J. Howes, J. Jones, **M. Li**, D. Manii, D. McLeod, C. Mayer, S. Sellick, S. Riahizadeh, H. Noroozi, M. Ali. Pan-Canadian Practice Guideline: Screening, Assessment and Management of Psychosocial Distress, Major Depression and Anxiety in Adults with Cancer. Canadian Association of Psychosocial Oncology and the Canadian Partnership Against Cancer; 2015 Jul. Available from: http://www.capo.ca/wp-content/uploads/2010/10/Distress_guideline_CAPO_201507311.pdf.

17. **M. Li**, E.B. Kennedy, N. Bryne, C. Gerin-Lajoie, E. Green, M.R. Katz, H. Keshavarz, S.M. Sellick. The Management of Depression in Patients with Cancer; 2015 May. Available from: https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=340750.

18. J. Anderson, M. Arab, D. Bell, F. Bennie, M.C. Blais, D. Budz, B. Bultz, D. Bulych, H. Campbell-Enns, L. Cleghorn, V. Collacutt, S.Damore-Petingola, L. Dobbin, K. Fenn, N. Ferguson, L. Fillion, M. Fitch, S. Groff, D. Howell, J. Howes, A.Hughes, M. Kennedy, D. Lamoureux, K. McQuaid-Duffy, M. Lessard, K. Levy, **M. Li**, A. Macedo, J. Mathieu, C. Mayer, D. McLeod, I. Nicoll, A. Syme, J. Taylor-Brown, L. Watson, A. Williams and K. Yue. Screening for Distress, the 6th Vital Sign: A Guide to Implementing Best Practices in Person-Centred Care. Canadian Partnership Against Cancer, Cancer Journey Portfolio, 2012 Sept. Available from: http://www.virtualhospice.ca/Assets/Distress-%20CPAC_20150713161546.pdf.

19. G. Turnbull, F. Baldassarre, P. Brown, J. Hatton-Bauer, **M. Li**, S. Lebel, L. Durkin. Psychosocial healthcare for cancer patients and their families: A Framework to Guide Practice in Ontario and Guideline Recommendations. Program in Evidence-Based Care Series, Cancer Care Ontario; 2010. Available from: www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=83597.

Online Resources

20. **M. Li**. Medical Assistance in Dying (MAiD) in Practice. Canadian Association of Psychosocial Oncology Webinar. 2017. Available from: http://www.capo.ca/free-webinars/.

21. **M. Li**, G. Rodin. Management of Depression in Cancer Patients webcast. International Psycho-Oncology Society Multilingual Core Curriculum Webcast. 2014. Available from: http://ipos-society.org/multilingual-core-curriculum-in-psycho-oncology/multilingual-core-curriculum-english-en/.

22. **M. Li.** SMGs into Practice: Clinical application of the Psychosocial Distress, Major Depression and Anxiety symptom Management Guideline. Canadian Association of Psychosocial Oncology Webinar. 2015. Available from: http://www.capo.ca/free-webinars/.

3. NON-PEER-REVIEWED PUBLICATIONS

Magazine Entries

23. K. Miller, **M. Li**. Understanding the Breadth and Depth of the Subspecialty: Psycho-Oncology. Psychiatric News, American Psychiatric Association, Feb 1, 2019. Available at https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.2a20

24. **M. Li,** G. Rodin. Personalized Medicine and MAiD at UHN. Cancer Knowledge Network, June 28, 2017. Available at https://cancerkn.com/personalized-medicine-maid-uhn/

25. **M. Li.** Meet your Colleague. Provincial Psychosocial Oncology Newsletter. Cancer Care Ontario. Winter 2014, 8th Edition.

26. J. Ellis, E. La Croix, **M. Li**. Tips on Assessment and Management of Distress in the Oncology Clinic. Hot Spot, Newsletter of the Rapid Response Radiotherapy Program. 2013;15(4).

27. **M. Li.** Treatment of Depression in Cancer: State of the Evidence. Provincial Psychosocial Oncology Newsletter. Cancer Care Ontario. Fall 2012, 6th Edition.

28. **M. Li**, A. Macedo. What's Function Got to Do With It? DART Matters-PMH Cancer Program News. 2011 Nov.

29. **M. Li**, A. Macedo. Enhancing Equal Access to Care for All. DART Matters-PMH Cancer Program. 2011 Oct.

30. **M. Li**, A. Macedo. FAQ introduction to DART. DART Matters-PMH Cancer Program News. 2011 May.

31. **M. Li**, A. Macedo. DART at PMH. Provincial Oncology Nursing News. 2010 Dec.

32. **M. Li**, A. Macedo. The Distress Assessment And Response Tool (DART): Enhancing Inter-professional and Patient Centered Care. Provincial Psychosocial Oncology Program Newsletter. 2010 Oct.

33. **M. Li**, A. Macedo. The Distress Assessment and Response Tool at PMH. Medical Post. 2010 May.

34. **M. Li**, A. Macedo. Coming Soon to a Clinic Near You: DART. PMH Psychosocial Nursing. 2010;2(2).

35. **M. Li**, A. Macedo. Screening for Distress, the 6th Vital Sign: The Distress Assessment and Response Tool (DART). PMH Cancer Program News. 2010;5(3).

36. Getting Back on Track, Life After Breast Cancer Treatment. Canadian Breast Cancer Foundation. 2010.

37. **M. Li**. Psychosocial Oncology – Treating the Cancer and the Patient. GI Health, Gastro Intestinal Newsletter. 2008;2(4):2.

Media Interviews

1. R. Piana. Is Medical Assistance in Dying Compassionate Care? ASCO Post, 2017, Nov 25.
2. A.E. Cha. It's not pain but "existential distress" that leads people to assisted suicide, study suggests. The Washing Post, 2017, May 26.
3. K. Lunau. Doctor-Assisted Dying Has Been "Normalized" in Just One Year. Motherboard. 2017, May 24.
4. N. Hune-Brown. How to End a Life. Toronto Life. 2017 May 23.
5. N. Cameron. Life Sentence. Maissoneuve. 2014 Nov 28.
6. C. Hawkes. The Answer to Cancer. More. 2010 Oct.
7. Breast Cancer and Depression. Moods Magazine. 2006:25-26.
8. CBC the National. On the death of Jack Layton. Aug 23, 2011.

4. SUBMITTED PUBLICATIONS

Journal Articles

1. D. Howell, Z. Rosberger, C. Mayer, R. Faria, M. Hamel, A. Snider, D. Bryant-Lukosius, N. Montgomery, M. Mozuraitis, **M. Li**. Integration of Patient Reported Outcomes in Real-World, Multisite Cancer Practices for Personalized Patient Management: Impact on Distress, Activation and Emergency Visits, J. Clin. Oncol.

2. S.M.H. Alibhai, H. Breunis, J. Matelski, N. Timilshina, A. Kundra, C-H Lee, **M. Li**. Age-related cytokine effects on cancer-related fatigue and quality of life in acute myeloid leukemia, J Geriaric Oncol.

3. J. Zhang, S. El-Majzoub, **M. Li**, T. Ahmed, J. Wu, M.L. Lipman, G. Moussaoui, K.J. Looper, M. Novak, S. Rej, I. Mucsi. Symptom burden as measured by Edmonton Symptom

Assessment System predicts subsequent healthcare use in patients with end stage kidney disease. Am J Nephrology.

4. W. Shi, S. Misra, M. McCusker, J. Su, **M. Li**, J. Williams, W. Xu, L.S. Ghoraie, R. Sutherland, K. Han, M. Minden, S. Bratman, K.W. Yip, F-F Liu. The Impact of Inflammatory Biomarkers and Hematopoietic Stem Cells on Behavioral Symptoms in Breast Cancer Patients Undergoing Adjuvant Radiation Therapy. Cancer.

F. Presentations and Special Lectures

1. INTERNATIONAL

Invited Lectures and Presentations

2015 Dec 7 **Invited Lecturer**. "Easier Said Than Done": Successful Implementation of the Distress Assessment and Response Tool (DART) Program (teleconference presentation) at the Princess Margaret Cancer Centre. American Psychosocial Oncology Society and Yale School of Nursing Screening for Psychosocial Distress Program meeting. Presenter: **M. Li**.

2015 Nov 2 **Invited Lecturer**. "Easier Said Than Done": Implementation of the Distress Assessment and Response Tool (DART) Program at the Princess Margaret Cancer Centre. Peiking University Cancer Hospital. Beijing, China. Presenter: **M. Li**.

2015 Jun 5 **Invited Lecturer**. "Easier Said Than Done": Implementation of the Distress Assessment and Response Tool (DART) Program at the Princess Margaret Cancer Centre. Dukoff Memorial Lecture Memorial Sloan Kettering Cancer Centre, New York, USA. June 5, 2015 Presenter: **M. Li**.

2014 Nov 23 **Invited Lecturer**. A Condensed Guide to having Conversations about Palliative Goals of Care. Grand Rounds, Kuwait Cancer Control Centre. Kuwait. Presenter: **M. Li**.

Presented and Published Abstracts

2019 May Phase 2 trial of Symptom screening with Targeted Early Palliative care (STEP) for patients with advanced cancer. C. Zimmermann, B. Hannon, M.K. Krzyzanowska, **M. Li**, G. Rodin, A. Pope, N. Swami, M. Giruparajah, D. Howell, A.M. Oza, D. Warr, J.J. Knox, N.B. Leighl, S.S. Sridhar, R.M. Prince, S.Lheureux, A.R. Hansen, C. Booth, D.J. Dudgeon, L.W. Le, STEP Trial Group. #265509. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, IL.

2019 May Predictors of Financial Toxicity Among Head and Neck Cancer Patients: A Prospective Cohort Study. J.R. de Almeida, K. Hueniken, L. Eng, M. Giuliani, J. Ringash, A.R. Hansen, G. Liu, W. Xu, **M. Li,** D.P. Goldstein. #266665. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, IL.

2019 Feb Medical Assistance in Dying (MAID) in a Tertiary Care Medical Center in Canada: Implications for Oncology. G.K. Shapiro, **M. Li**, G. Rodin. 16th American Psychosocial Oncology Society (APOS) Annual Conference, Atlanta, Georgia.

2018 Nov Machine Learning to Identify Cytokine-based Symptom Clusters in Ovarian Cancer. The Lancet Summit: Inflammation and Immunity in Disorders of the Brain and Mind. Barcelona, Spain. **M. Li**, R.Y. Klein, M. McCusker, S. Ferguson, H. Mackay, C. Paige, G. Rodin, B. Haibe-Kains.

2018 Nov Longitudinal Distress Assessment and Response Tool (DART) Screening in Adults with Aggressive Fibromatosis: High Prevalence of Persistent Emotional Distress. Connective Tissue Oncology Society Annual Meeting, Rome, Italy. A.A. Gupta, N. Byers, S. Burtenshaw, K. Ingley, C. Swallow, S. Brar, P. Ferguson, J. Wunder, A. Razak, R. Gladdy, R. Klein, **M. Li**

2018 Oct Machine Learning to Identify Cytokine-based Symptom Clusters in Ovarian Cancer. International Psychosocial Oncology Society 20th Annual Meeting 2018, Hong Kong. **M. Li**, R. Y. Klein, M. McCusker, S. Ferguson, H. Mackay, C. Paige, G. Rodin, B. Haibe-Kains.

2018 Oct Medically Assisted Dying in Oncology and Beyond: A Tale of Three Countries. International Psychosocial Oncology Society 20th Annual Meeting 2018, Hong Kong. G. Rodin, S. Ellen, **M. Li,** L. Deliens.

2018 Oct Impact of the Distress Assessment and Response Tool (DART) program on patient care outcomes at the Princess Margaret Cancer Centre. International Psychosocial Oncology Society 20th Annual Meeting 2018, Hong Kong. **M. Li**, A. Kundra, B. Gascon, L. McColl, S. Bagha, A. Tweedy, Y.W. Leung, A. Macedo, G. Rodin.

2018 Oct Preparing Clinicians to Provide High Quality Psychosocial Care: Results From An Online Course "Management of Depression and Anxiety in Cancer" International Psychosocial Oncology Society 20th Annual Meeting 2018, Hong Kong. M.J. Esplen, **M. Li**, J. Wong.

2018 Oct INKeD-PC: Intranasal Ketamine for Depression in Patients with Cancer Receiving Palliative Care: A Phase II Open-label Proof-of-Concept Clinical Trial. International Psychosocial Oncology Society 20th Annual Meeting 2018, Hong Kong. J. Rosenblat, C. Lo, R. McIntyre, J. Bryson, B. Hannon, E. Mak, C. Zimmermann, G. Rodin, **M. Li**

2018 May INKeD-PC: Intranasal Ketamine for Depression in Patients with Cancer Receiving Palliative Care: A Phase II Open-label Proof-of-Concept Clinical Trial. *APA Junior Investigator Research Colloquium*. New York City, NY. J. Rosenblat, C. Lo, R. McIntyre, J. Bryson, B. Hannon, E. Mak, C. Zimmermann, G. Rodin, **M. Li**

2017 Aug Managing Cancer And Living Meaningfully (CALM): Effectiveness of a psychological intervention for patients with advanced cancer. International Psychosocial Oncology Society 19th Annual Meeting 2017, Berlin, Germany. G. Rodin, C. Lo, **M. Li**, A. Rydall, R. Nissim, C. Malfitano, J. Shnall, C. Zimmermann, S. Hales. Psycho-oncology 26:63-64, 2017.

2017 Aug Improving pajtient experience and health outcomes using electronic patient-reported outcome measures: effects on disress and health outcomes. International Psychosocial Oncology Society 19th Annual Meeting 2017, Berlin, Germany. **M. Li**, D. Howell, Z. Rosberger. Psycho-oncology 26:32-33, 2017.

2017 July Inflammatory cytokines and hematopoietic stem cells are associated with fatigue and insomnia in breast cancer patients undergoing adjuvant radiation therapy. W. Shi, K. Han, **M. Li**, J. Williams, M. McCusker, J. Su, W. Xu, S. Bratman, K. Yip, F-F Liu. AACR Annual Meeting, Washington, DC. Cancer Res. 77(13 Supplement):4752, 2017.

2017 June Understanding the quantitative relationship between cytokines and patient-reported outcomes and exploring the significance of age in adults with acute myeloid leukemia (AML). #190671. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, IL. Presenter(s): S.M.H. Alibhai, H. Breunis, J. Matelski, **M. Li**.

2017 June A person-centered e-proms multi-faceted intervention to improve patient experience and health outcomes: A multi-site implementation study in diverse ambulatory oncology practices. D. Howell, **M. Li**, Z. Rosberger, N. Montgomery, C. Mayer, A. Snider, D. Bryant-Lukosius, M. Hamel, R. Faria, L.

Martelli, A. Macedo. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, IL. J. Clin. Onc. 35(8 Supplement):182, 2017.

2017 June Association of fatigue and insomnia with inflammatory cytokine and hematopoetic stem cell levels in breast cancer patients undergoing adjuvant radiation therapy. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, IL. F-F. Liu, W. Shi, M. McCusker, **M. Li**, J. Su, J. Williams, T. Spence, W. Xu, K. C-Z Han, S. Victor Bratman, K. Yip J. Clin. Onc. 35(15 Supplement):e12048, 2017.

2017 May Psychosocial Distress in chronic Kidney disease: Benefits of Kidney Transplantation. Abstract # 2105. American Transplant Congress (ATC), Chicago, IL. Presenter(s): C. Richardson, M. Novak, **M. Li**, I. Musci.

2016 Oct Improving the Quality of Distress Management and Psychosocial Care Using Electronic Patient-Reported Outcomes (e-PRO) and Multifaceted Knowledge Translation Strategies to Improve Distress Management: A Multi-Site Study in Ambulatory Cancer Care in Ontario and Quebec, Canada. International Psychosocial Oncology Society (IPOS) 18th Annual Meeting. Dublin, Ireland. Psycho-Oncology 25 (SP.S 3):157-159, 2016. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, and the iPEHOC Investigator Team.

2016 June Multi-site implementation of patient-reported outcome measures for personalized care and patient activation in symptom management. American Society for Clinical Oncology (ASCO) Annual Meeting, Chicago, Illinois. D. Howell, **M. Li**, Z. Rosberger, N. Montgomery, C. Mayer, A. Snider, D. Bryant-Lukosius, M. Hamel, R. Faria, L. Martelli, A. Macedo, A. Krasteva, L. C. Barbera, iPEHOC Investigator Group. J. Clin. Onc. 34 (15 Supplement):e21665, 2016.

2015 Sep The Relationship between Circulating CD34+ Cells with Mental Fatigue and Insomnia, during Adjuvant Breast Cancer Radiation Therapy (RT). #9536 56th Annual Meeting American Society for Radiation Oncology (ASTRO). San Francisco, California, United States. Presenter(s): K. Han, T. Lymberiou, **M. Li**, W. Shi, X Shen, W. Xu, P. Catton, A. Fyles, R. Sutherland, R. Carlson, M. Yap, M Minden, F.F. Liu.

2015 Jun Screening for Psychosocial Distress: A Transformative Journey. American Society for Clinical Oncology (ASCO) Annual Meeting. Chicago, Illinois, United States. J. Clin. Oncol. 34(15 Supplement):e18176, 2016. Presenter(s): T. Stuart McEwan, A. Macedo, G. Rodin, S. Bagha, Y. Leung, L. McColl, A. Twiddy, K. Davison **M. Li**.

2014 Oct Routine clinical qualilty of life measurement for head and neck cancer patients: example from a province-wide oncology initiative. 21st Annual Conference of the International Society for Quality of Life Research, Berlin Germany. Presenter(s): J. Ringash, A. Macedo, **M. Li**, T. Stuart-McEwan, A. Archer, A. Hope, B. O'Sullivan, J. Waldron. Quality of Life Research 23:55-6.

2014 Implementation of Distress Assessment and Response Tool (DART) Screening Program in Kuwait Cancer Control Center (KCCC). International Psychosocial Oncology Society (IPOS) 16th Annual Meeting. M. Alawadhi, H. Abdulkareem, A. Hamadah, **M. Li**, G. Rodin. Psycho-Oncology 23:327-328, 2014.

2014 P.2.d.054. A pilot, open-label, 8-week study evaluating the efficacy of adjunctive minocycline for the treatment of bipolar I/II depression. Presenter(s): J. Soczynska, S.H. Kennedy, M. Alsuwaidan, R. Mansur, **M. Li**, M.P. McAndrews, E. Brietzke, V. Taylor, R.S. McIntyre. European Neuropsychopharmacology. 24:S445-S446.

2013 Do quality of life and physical function at diagnosis predict short-term outcomes during intensive chemotherapy in acute myeloid leukemia patients? ASCO Abstract #115053. Presenter(s): N. Timilshina, H. Breunis, J. Brandwein, M. Minden, V. Gupta, **M. Li**, G.Tomlinson, R. Buckstein, S. Alibhai. Journal of Clinical Oncology 31(15_suppl): 7067.

2013 May Quality of life (QOL) and physical function in one-year adult and elderly survivors of acute myeloid leukemia (AML). ASCO Abstract #115409. Chicago, Illinois, United States. Presenter(s): S. Alibhai, H. Breunis, N. Timilshina, M. Minden, V. Gupta, R. Buckstein, **M. Li**, G. Tomlinson, J. Brandwein. abst #7071.

2013 The Relationship between Circulating CD34+ Cells with Fatigue and Cytokines, during Adjuvant Breast Cancer Radiation Therapy (RT). 55th Annual Meeting American Society for Radiation Oncology (ASTRO). San Francisco, California, United States. Presenter(s): K. Han, T. Lymberiou, **M. Li**, W. Shi, X Shen, W. Xu, P. Catton, A. Fyles, R. Sutherland, R. Carlson, M. Yap, M Minden, F.F. Liu.

2012 Distress Screening for Dialysis Patients: The Distress Assessment Response Tool (DART). American Society of Nephrology Kidney Week. San Francisco, California, United States. Presenter(s): M. Novak, J.M. Dell, C.T. Chan, J.M. Bargman, S.V. Jassal, S. Parikh, **M. Li**. Abstract Number: 6007.

2012 Hope and Ontario Patient Reported Outcomes of Symptoms and Toxicity Applied Cancer Research Unit. Presenter(s): G. Liu, D. Howell, A.P. Cosio, M.K. Krzyzanowska, **M. Li**, G. Rodin, M.D. Brundage, A.J. ASCO Quality of Care Symposium. San Diego, California, United States. Creation of On-PROST: The Ontario patient-reported outcomes of symptoms and toxicity applied clinical research unit. Journal of Clinical Oncology. 30(34):46, 2012.

2011 Sources of spiritual well-being in advanced cancer. Canadian Association of Psychosocial Oncology Annual Meeting. Toronto, Ontario, Canada. Presenter(s): C. Lo, C. Zimmermann, L. Gagliese, **M. Li**, G. Rodin. Symposium: Thinking outside the box: Challenging received wisdom in psychosocial oncology. Reference #250.

2011 Age-dependent effects of intensive chemotherapy (IC) on quality of life (QOL) and physical function in patients with acute myeloid leukemia (AML). American Society of Clinical Oncology Annual Meeting. Chicago, Illinois, United States. Presenter(s): H. Z. Mohamedali, H. Breunis, J. Brandwein, **M. Li**, N. Timilshina, M. Minden, G. A. Tomlinson, S. M. H. Alibhai. Abstract #843388.

2009 The association between cytokines and cognitive performance in bipolar disorder. XXXVI International Congress of Physiological Sciences. Kyôto [Kyoto], Japan. Presenter(s): J. Soczynska, S. Kennedy, **M. Li**, H. Woldeyohannes, R. McIntyre. J. Physiol. Sci. 59. Supp 1 P5AM-9-6.

2008 The association between cytokines and cognitive performance in euthymic individuals with bipolar disorder. XXVI Collegium Internationale Neuro-Psychopharmacologicum Congress. Munich, Germany. Presenter(s): Soczynska, R. McIntyre, **M. Li**, S. Kennedy. Int. J. Neuropsychopharm. Supp 1: 182 P-04.24.

2007 May Psychoneuroimmunology Research Society Meeting Cytokine profiles in cancer: correlations with sickness behaviors and depression. Arcachon, France. Presenter(s): 14. **M. Li**.

2001 Monozygotic twins discordant for Beckwith-Wiedemann syndrome also have different patterns of KvDMR1 methylation and KCNQ1OT1 allelic transcription in the chromosome 11p15 imprinted region. American Society of Human Genetics 51st Annual Meeting. San Diego, California, United States. Presenter(s): R. Weksberg, J. Nishikawa, YL. Fei, C. Shuman, T. Stockley, L. Best, D. Chitayat, J. Cameron, **M. Li**, P. Sadowski, J. Squire. American Journal of Human Genetics. 69(4):552.

2000 Oct p57KIP2 mutations associated with loss of IGF 2 imprinting in Beckwith-Wiedemann syndrome. American Society of Human Genetics Annual Meeting. Abstract #31. Philadelphia, Pennsylvania, United States. Presenter(s): R. Weksberg, **M. Li**, YL. Fei, C. Shuman, D. Chitayat, J. Atkin, R.M. Pauli, J.A. Squire.

1999 Oct Glypican 3 (GCP3) deletions: the phenotypic spectrum in overgrowth syndromes. American Society of Human Genetics Annual Meeting. San Francisco, California, United States. Presenter(s): R. Weksberg, **M. Li**, C. Shuman, E. Cutiongco, H.A. Bender, C. Stevens, L. Wilkins-Haug, S.L. Wong, J. Squire.

1994 Regulation and expression of MDR genes in the intestinal epithelium. Presenter(s): **M. Li**, R.L. Zastawny, V. Ling, R.N. Buick. Mol. Biol. of the Cell Suppl. 5:209a.

1994 Transcriptional regulation of the grip family member, OCI-5. Presenter(s): **M. Li**, N.G. Miyamoto, R.N. Buick. Mol. Biol. of the Cell Suppl. 5:336a.

2. NATIONAL

Invited Lectures and Presentations

2018 Oct 21 **Invited Lecturer**. Medical Assistance in Dying in Clinical Practice. Federation of Chinese American and Chinese Canadian Medical Society Conference. 2018. Toronto, ON.

2018 May 31 **Invited Lecturer**. A New Era of Care – MAID Panel. Canadian Association of Psychosocial Oncology Annual Meeting Keynote Plenary. 2018. Toronto, ON. Presenter(s): **M. Li**, J. Downey, S. Buchman.

2018 May 30 **Invited Lecturer**. Medical Assistance in Dying: A Training Workshop for Assessors and Providers. Canadian Association of Psychosocial Oncology Annual Meeting Pre-Conference Workshop. 2018. Toronto, ON. Presenter(s): **M. Li**, D. Kain, S. Buchman.

2017 Sept 13 **Invited Speaker**. Medical Assistance in Dying(MAID): From Legislation to Implementation. 2017 Canadian Academy of Psychosomatic Medicine. Ottawa, ON.

2017 May 10 **Invited Speaker**. Medical Assistance in Dying(MAID): From Debate to Implementation. 2017 Annual NICE Knowledge Exchange (ANKE), National initiative for the Care of the Elderly. Toronto, ON.

2017 Mar 4 **Invited Lecturer**. "*Easier Said Than Done*": Lessons Learned from Implementation of the Distress Assessment and Response Tool (DART) Program. CAN-PRO meeting. Calgary, AB.

2009 Apr **Invited Lecturer**. The Princess Margaret Hospital Distress Screening and Response Program. Colorectal Cancer Association of Canada Roundtable. Vancouver, British Columbia, Canada.

Presented and Published Abstracts

2019 May A Multiple Streams analysis of Medical Assistance in Dying in Canada: Why here? Why now? G.K. Shapiro, **M. Li**, G. Rodin. Canadian Association for Health Services and Policy Research CAHSPR Scientific Conference, Halifax, Nova Scotia

2018 Oct Intranasal Ketamine for Depression in Patients with Cancer Receiving Palliative Care: A Protocol for a Phase II, Open-label, Proof-of-Concept Clinical Trial. Presented at *CPA Junior Investigator Research Colloquium* in Vancouver, BC. J. Rosenblat, C. Lo, R. McIntyre, J. Bryson, B. Hannon, E. Mak, C. Zimmermann, G. Rodin, **M. Li**

2018 Sept Experiences and Challenges with Medical Assistance in Dying (MAID). Canadian Psychiatric Association Annual Meeting 2018. Toronto, ON. Presenter(s): **M. Li**, L. Thorpe.

2018 May Management of Persistent Distress in Cancer: A Case-Based Workshop. Canadian Association of Psychosocial Oncology Annual Meeting 2018. Toronto, ON. Presenter(s): **M. Li**, M. Katz.

2018 May Screening for Distress and Patient Reported Outcomes: Where are we and where are we going? Canadian Association of Psychosocial Oncology Annual Meeting 2018. Toronto, ON. Presenter(s): B. Bultz, Z. Rosberger, E. Green, D. Howell, J. Howes, C. Mayer, **M. Li**, D. Bulych.

2018 May Medical Assistance in Dying: Guideline Development and 20 Month Experience at the University Health Network. Canadian Association of Pharmacy in Oncology 2018 Conference. Ottawa, ON. Presenter(s): C. Dara, A. Seto, R.J. Edralin, **M. Li**.

2018 May The impact of inflammatory cytokines and biopsychosocial factors on acute pain after breast cancer surgery. Canadian Pain Society 39th Annual Scientific Meeting. Montreal, PC. Presenter(s): S. Goodall, L. Gauthier, **M. Li**, M. Connor, V. Chan, A. Easson, L. Gagliese

2017 May Using Patient Reported Outcome Measure for Personalized Cancer Care: Impact on Patient Activation and Health Care Utilization. Abstract #: 1095. Canada's Applied Research in Cancer Control Conference (ARCC). Toronto, Ont. Presenter(s): N. Montgomery, D. Howell, Z. Rosberger, **M. Li**.

2017 May *"Not really helpful to me"*: Distressed head and neck cancer patients' perceptions and experiences with distress screening. Canadian Association for Psychosocial Oncology Conference. Vancouver, British Columbia. Presenter(s)Title: T. Cheng, S. Bagha, J. Shaheed, J. Ellis, A. Macedo,

M. Li, G. Rodin.

2017 May Improving Patient Experience and Health Outcomes Using Electronic Patient-Reported Outcome Measures. S227. Canadian Association for Psychosocial Oncology Conference. Vancouver, British Columbia. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, and the iPEHOC Investigator Team

2017 May Depression self-care intervention for cancer survivors: feasibility and acceptability. B109. Canadian Association of Psychosocial Oncology Conference, Vancouver, British Columbia. Presenter(s): Lambert S, McCusker J, Yaffe M, Faria R, **Li M**, de Raad M, Magalhaes M, Belzile E.

2017 May Engaging Psychosocial Clinicians In A Conversation About Maid: Implications For Clinical Practice. S229. Canadian Association for Psychosocial Oncology Conference. Vancouver, British Columbia. Presenter(s): C. Mayer, M. Katz, J. Romanko, R. Mallet, **M. Li.**

2016 Oct Ethnicity and psychosocial distress among kidney transplant recipients. CST-CNTRP-SQT Joint Scientific Meeting Québec City, Québec. Presenter(s): C. Richardson, D. Wong, H. Ford, S.Cao, L. Ugenti, A. Sissons, N. Edwards, M. Novak, **M. Li**, I. Musci.

2016 Oct Psychosocial distress in kidney transplant recipients – a pilot study. CST-CNTRP-SQT Joint Scientific Meeting Québec City, Québec. Presenter(s): D. Belenko, C. Richardson, D. Wong, A. Sissons, E. Tang, H. Wong, **M. Li**, M. Novak, I. Mucsi.

2016 May Uncovering the experiences of distressed head and neck cancer patients that influence their need, desire for and acceptance of psychosocial care: A grounded theory study. B132. Canadian Association for Psychosocial Oncology Conference. Halifax, Nova Scotia, Canada. Presenter(s): T. Cheng, S. Bagha, J. Shaheed, J. Ellis, A. Macedo, **M. Li**, G. Rodin.

2016 May The CCO Management of Depression in Patients with Cancer Guidelines: Clinical realities and opportunities for interventional research. W211. Canadian Association for Psychosocial Oncology Conference. Halifax, Nova Scotia, Canada. Presenter(s): M. Katz, N. Bryne, C. Gerin-Lajoie, E. Green, S.M. Sellick. **M. Li**.

2016 May Implementation of distress screening and patient-reported outcome measures: Successes and challenges across the iPEHOC sites in Ontario and Quebec. S107. Canadian Association for Psychosocial Oncology Conference. Halifax, Nova Scotia, Canada. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, N. Montgomery and the iPEHOC Investigator Team.

2016 May Expectations of postoperative pain and recovery: The role of preoperative patient factors. Canadian Pain Society Conference. Vancouver, British Columbia, Canada. Presenter(s): S. Ghandeharian, A. Richardson, A.K. Macpherson, L.R. Gauthier, G. Koren, **M. Li**, G. Rodin, A.M. Easson, V.W.S. Chan, L. Gagliese.

2015 Oct 2 Intranasal ketamine for depression in patients with cancer receiving palliative care: A protocol for a phase II, open-label, proof-of-concept clinical trial. Canadian Psychiatric Association Junior Investigator Research Colloquium. Ottawa, Ontario, Canada. Presenter(s): J. Rosenblat, C. Lo, R. McIntyre, J. Bryson, R. Whitty, B. Hannon, E. Mak, G. Rodin, C. Zimmermann, **M. Li**.

2015 Oct Distress Assessment and Response Tool (DART) at Princess Margaret: How to Engage Clinicians. International Society for Quality of Life Research

(ISOQOL) Annual Conference. Vancouver, British Columbia, Canada. Wual of Life Res. 24:184, 2015. Presenter(s): A. Macedo, **M. Li**, G. Rodin, S. Bagha, Y. Leung, L. McColl, A. Twiddy, K. Davison and T. Stuart-McEwan.

2015 Mar Improving patient experience and health outcomes (iPEHOC): A multi-site project to develop and evaluate implementation of meaningful patient-reported outcomes (PROMs) and experiences (PREMs) designed to engage cancer patients and healthcare providers in improving care delivery. Canadian Association of Psychosocial Oncology Annual Conference. Montreal, Quebec, Canada. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, C. Mayer.

2015 Mar An exploratory analysis of psychosocial oncology services and subsequent healthcare utilization and costs for Ontario cancer patients at high risk for depression. Canadian Association of Psychosocial Oncology Annual Conference. Montreal, Quebec, Canada. Presenter(s): Z. Ismail, D. Han, J. Beca, R. Tabing, D. Yuen, J. Hoch, **M. Li**, T. Cadotte & E. Green.

2014 The Relationship between Circulating CD34+ Cells with Mental Fatigue and Insomnia, during Adjuvant Breast Cancer Radiation Therapy (RT). 56th Annual Meeting Canadian Association of Radiation Oncology (CARO), 2014T. Presenter(s): Lymberiou, K. Han, **M. Li**, W. Shi, X Shen, W. Xu, P. Catton, A. Fyles, R. Sutherland, R. Carlson, M. Yap, M Minden, F.F. Liu.

2013 Apr Psychological Distress in Pancreatic Cancer Patients compared to Patients with Other Cancers as measured by the Distress Assessment Response Tool (DART). Canadian Association of Psychosocial Oncology Annual Conference. Ottawa, Ontario, Canada. Presenter(s): P. Fitzgerald, Y. Leung, **M Li**, G. Rodin.

2013 The Relationship between Circulating CD34+ Cells with Fatigue and Cytokines, during Adjuvant Breast Cancer Radiation Therapy (RT). 55th Annual Meeting Canadian Association of Radiation Oncology (CARO), 2013T. Presenter(s): Lymberiou, K. Han, **M. Li**, W. Shi, X Shen, W. Xu, P. Catton, A. Fyles, R. Sutherland, R. Carlson, M. Yap, M Minden, F.F. Liu.

2012 Apr Predictors of Clinical Response to Screening for Distress in S250 Screening for Distress, the 6th Vital Sign: understanding the patient and provider perspective in 4 Canadian Jurisdiction. Canadian Association of Psychosocial Oncology Annual Conference. Vancouver, British Columbia, Canada. Presenter(s): S. Bagha, L. McColl, D. Breen, M. Wyatt, A. Macedo, B. Fitzgerald, G. Rodin, **M. Li**.: understanding the patient and provider perspective in 4 Canadian Jurisdiction.

2012 Apr Longitudinal Trends in Physical Symptoms, Psychosocial Needs and Practical Concerns based on the Distress Assessment and Response Tool at Princess Margaret Hospital in S251 Screening for Distress, the 6th Vital Sign: using data to understand and enhance the patient experience. Canadian Association of Psychosocial Oncology Annual Conference. Vancouver, British Columbia,

Canada. Presenter(s): A. Macedo, **M. Li**, S. Bagha, V. Boquiren C. Zimmermann, G. Rodin.

2012 Apr Suicidal Ideation and Intent among Cancer Patients: An analysis from the Distress Assessment and Response Tool (DART) at Princess Margaret Hospital in S252 Screening for Distress, the 6th Vital Sign: A call for Interprofessional Collaboration through a Series of Case Studies. Canadian Association of Psychosocial Oncology Annual Conference. Vancouver, British Columbia, Canada. Presenter(s): Y. W. Leung, **M. Li**, A. Macedo, G. Rodin.

2011 Sep DART Supports Effective Communication Between Patients and the Health Care Team. Canadian Association of Nursing Oncology Conference. Halifax, Nova Scotia, Canada. Presenter(s): N. Gregorio, A. Macedo, **M. Li**, G. Rodin.

2011 May DART at PMH: Taking the Distress out of Screening for Distress: Reference #246. Canadian Association of Psychosocial Oncology Annual Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**, A. Macedo, G. Rodin.

2008 May Distress Screening in Cancer. Canadian Association of Psychosocial Oncology Annual Conference. Halifax, Nova Scotia, Canada. Presenter(s): **M. Li**.

2007 May Cytokine Profiles in Sickness Behaviours and Depression. Canadian Association of Psychosocial Oncology Annual Conference. Winnipeg, Manitoba, Canada. Presenter(s): **M. Li**.

3. PROVINCIAL / REGIONAL

Invited Lectures and Presentations

2018 Apr 22 Enhancing access to evidence based training in the management of grief and loss and depression through standardized online education. Hospice Palliative Care Ontario 2018 Annual Conference. Toronto, ON. Presenter(s): **M. Li**, J.Wong, M.J. Esplen.

2015 Feb 26 **Invited Speaker**. Burning Questions and Rapid Learning – Management of Psychosocial Symptoms. OCSMC Face to Face Meeting. Toronto, Ontario, Canada. Presenter: **M. Li**.

2013 Feb 27 **Invited Speaker**. Implementation of PROs for Depression and Anxiety. PSO Program Annual Meeting. Toronto, Ontario, Canada. Presenter: **M. Li**.

2012 Feb 3 **Invited Speaker**. SMGs into Practice: Anxiety and Depression, TC LHIN Regional KT event. Toronto, Ontario, Canada. Presenter: **M. Li**.

2011 Oct 14 **Invited Speaker**. Screening for Emotional Distress The 6th Vital Sign: The Distress Assessment and Response Tool (DART) at PMH. Provincial Psychosocial Oncology Program Rounds. Toronto, Ontario, Canada. Presenter: **M. Li**.

2008 Mar **Invited Speaker**. Screening tools used for psychosocial oncology assessment. Psychosocial Oncology Symposium, Cancer Care Ontario. Toronto, Ontario, Canada. Presenter: **M. Li**.

4. LOCAL

Invited Lectures and Presentations

2018 Jan 10 **Invited Speaker**. Integrating the comprehensive and focused assessment for anxiety/depression into the clnical interview. Cancer Care Ontario Anxiety and Depression Community of Practice. Toronto, ON.

2018 Jan 4 The PROs Promise – Clnical and Research Benefits of Routine Patient Reported Outcome Data Collection. Combined DMOH/RMP Rounds. Toronto, ON. Presenter(s): **M. Li**, G. Liu, D. Howell, M. Giuliani.

2016 Sep 24 **Invited Speaker**. The Distress Assessment and Response Tool (DART): Making Personalized Medicine More Personal. Canadian Fertility and Andrology Society Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2016 Jun 13 **Invited Speaker**. Distress Screening in Cancer: Implementation, Screening, Response and Evaluation. Pediatric Oncology Group of Ontario. AfterCare Education Day. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2016 Apr 18 Psychiatric Care on Medical Floors. Patient Centered Care Rounds, Princess Margaret Cancer Centre. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2015 Nov 15 Cytokines, Sickness Behaviours and Cancer: The Preview. Behavioural Health Sciences Research Seminar. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2015 Feb 3 The Distress Assessment and Response Tool (DART): Making Personalized Medicine More Personal. Personalizing Cancer Medicine Conference, Princess Margaret Cancer Centre. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2014 Dec 8 Cytokines and Symptom Clusters in Ovarian Cancer: a Machine Learning Approach to Identifying Intervention Targets. Behavioural Health Sciences. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2014 Oct 10 **Invited Speaker**. Responding to Low ESAS Scores for Anxiety, Depression and Well-Being. Community of Practice Event, Toronto LHIN. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2014 Apr 7 Psychoneuroimmunology & Depression in Cancer: The Long Awaited Sequel. Behavioural Health Sciences Research Seminar. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2013 Jan 28 Basic Science Questions in an Applied Research Environment: Attachment and the default mode network? Behavioural Health Sciences. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Nov 23 **Invited Speaker**. Complex Case Rounds – Psychiatric Management of the "Difficult Patient". Toronto Cancer Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Oct 25 **Invited Lecturer**. Treatment of Comorbid Conditions in Individuals with Major Depressive Disorder and Bipolar Disorder. Clinical Pearls for Clinical Practice. CANMAT Updates on the Complex Patient. Mississauga, Ontario, Canada. Presenter(s): **M. Li**.

2012 Sep 27 Art and Science: The Importance of Medical Communication in Cancer Patients. Princess Margaret Cancer Centre Innovation Rounds. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Sep 26 **Invited Speaker**. The Colorectal Cancer Journey: What Physicians Need to Know. Identification and Management of Psychosocial Distress during Diagnosis and Treatment of GI Cancer. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Aug 28 **Invited Speaker**. SMGs into Practice: Anxiety and Depression, Princess Margaret Nursing Lunch and Learn event. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Jun 15 Suicidality: Tip of the DART Iceberg. Patient Centred Care Rounds, Princess Margaret Cancer Centre. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Mar 10 **Invited Lecturer**. Psychiatric Needs of Cancer Patients. Toronto Psychopharmacology Update. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2012 Feb 3 **Invited Speaker**. SMGs into Practice: Anxiety and Depression. TC LHIN Regional KT event. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2011 Mar 12 **Invited Speaker**. Inflammation and Psychiatry. Toronto Psychopharmacology Update. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2010 Sep 24 Symposium S41: Neuroinflammatory Mediators of Comorbid Depression and Medical illness. Canadian Psychiatric Association 60th Annual Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2010 Jun 18 **Invited Speaker**. The lump in your throat when your patient has a lump in her breast: tips for supportive communication in breast cancer. Toronto Breast Cancer Symposium. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2009 Dec 7 Cytokine-induced Sickness Behaviour: An Inflammatory Basis for Mood and Physical Symptoms in Cancer. Behavioural Health Sciences Research. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2009 Oct 30 **Invited Speaker**. Cytokines and Sickness Behaviours: A biological basis for depression in cancer? Princess Margaret Hospital Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2009 Jun 23 **Invited Lecturer**. Cytokine-induced Sickness Behaviour: An Inflammatory Basis for Mood and Physical Symptoms in Cancer. Palliative Care Pain and Symptom Rounds. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2009 Mar 21 Causes and Consequences of Insomnia in High Risk Breast Cancer. Behavioural Health Sciences Research Seminar. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2008 May 21 Cytokines and Sickness Behaviours: A biological basis for depression in cancer? Ontario Cancer Institute Research Retreat. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2008 Apr 4 Distress Screening in Cancer: Challenges and Opportunities. Department of Psychiatry Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2008 Jan 7 Whose Distress is it Anyway? Balancing clinical and research interests in establishing standardized cancer distress screening. Behavioural Health Sciences Research Seminar. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2006 Dec 16 Psychoneuroimmunology and Genetics: A biological basis for depression in cancer? Psychosocial Oncology and Palliative Care Grand Rounds. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2006 Apr 3 Biological Predictors of Psychological Distress. Behavioural Health Sciences Research Seminar. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

Presented Abstracts

2018 Jun 21 INKeD-PC: Intranasal Ketamine for Depression in Patients with Cancer Receiving Palliative Care: A Phase II Open-label Proof-of-Concept Clinical Trial. Presented at *Harvey Stancer Research Day*. J. Rosenblat, C. Lo, R. McIntyre, J. Bryson, B. Hannon, E. Mak, C. Zimmermann, G. Rodin, **M. Li**

2018 Jan 19 An Innovative Bench to Bedside Pipeline to Guide Selection and Testing of Patient Reported Outcomes (PROs) for Personalized Symptom Management. Princess Margaret Cancer Conference Accelerating Precision Medicine 2018. Toronto, ON. Presenter(s): D. Howell, **M. Li**, C. Brown, A. Hope, M. Brundage, G. Rodin, G. Liu

2018 Jan 19 Using Patient Reported Outcome Measures for Personalized Cancer Care: Impact on Distress, Patient Activation and Health Care Utilization. Princess Margaret Cancer Conference Accelerating Precision Medicine 2018. Toronto, ON. Presenter(s): D. Howell, **M. Li**, Z. Roserger, N. Montgomery, C. Mayer, A. Snider, D. Bryant-Lukosius, M. Hamel, R. Faria, L. Martelli, A. Macedo, A. Krasteva & the IPEHOC Investigator Group

2016 May 8 Multi-site implementation of patient-reported outcome measures for personalized care and patient activation in symptom management. Applied

Research in Cancer Control (ARCC) Conference. Toronto, Ontario, Canada. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, N. Montgomery, C. Mayer, A. Snider, D. Bryant-Lukosius, M. Hamel, R. Faria, L. Martelli, A. Macedo, A. Krasteva, L. Barbera & the iPEHOC Investigator Group.

2016 Apr 18 Multi-site implementation of patient-reported outcome measures for personalized care and patient activation in symptom management. Cancer Care Ontario Research Day. Toronto, Ontario, Canada. Presenter(s): D. Howell, **M. Li**, Z. Rosberger, N. Montgomery, C. Mayer, A. Snider, D. Bryant-Lukosius, M. Hamel, R. Faria, L. Martelli, A. Macedo, A. Krasteva, L. Barbera & the iPEHOC Investigator Group.

2016 Feb Distress Assessment and Response Tool (DART) at Princess Margaret: How to Engage Clinicians. Princess Margaret Cancer Conference. Toronto, Ontario, Canada. Presenter(s): A. Macedo, **M. Li**, G. Rodin, S. Bagha, Y. Leung, L. McColl, A. Twiddy, K. Davison and T. Stuart-McEwan.

2014 Psychological Distress in Pancreatic Cancer Patients compared to Patients with Other Cancers as measured by the Distress Assessment Response Tool (DART). 40th Annual Harvey Stancer Research Day. Toronto, Ontario, Canada. Presenter(s): P. Fitzgerald, Y. Leung, **M. Li,** G. Rodin.

2012 Jun What Predicts Persistent Suicidal Ideation. 38th Annual Harvey Stancer Research Day. Toronto, Ontario, Canada. Presenter(s): Y.W. Leung, C. Lo, A. Payne, **M. Li**, G. Rodin.

2007 Jun Cytokine Profiles in Cancer: Correlations with Sickness Behaviours and Depression. Harvey Stancer Research Day. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

2001 Jul Identifying late-onset dementia genes in the canine model. 7th Annual Canine Cognition and Aging Conference. Toronto, Ontario, Canada. Presenter(s): **M. Li**.

G. Teaching and Design

1. INNOVATIONS AND DEVELOPMENT IN TEACHING AND EDUCATION

2016 – present Interprofessional Medical Assistance in Dying (MAiD) Education to UHN nursing and physician groups. Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto
Multi-faceted knowledge translation approach with in-person case-based seminars, production of a MAiD e-learning module, patient information pamphlets, and development of MAiD internet and intranet webpages.

2016	Medical Assistance in Dying (MAiD): A Patient-Centred Approach to the Provision of Care for Physicians and Other Health Care Professionals. Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto *Development and provision of two MAiD training workshops for national and regional healh care providers, delivered on Aug. 19, 2016 and Dec 2. 2016.*
2016 - present	Psychiatric Management on Medical Floors, for nurses and oncologists on in-patient units at Princess Margaret Cancer Centre, Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto *Education module to nursing and oncology staff on the mental health act and safety protocols for certified patients on a medical floor. Dissemination through on-line webcast, patient-centred care rounds, and unit based teaching.*
2011 - present	SCID for DSM-IV Depression in Cancer Patients for research assistants, Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto *Behavioural Health Sciences Research division, University Health Network. Development of training program and ongoing supervision for research staff in structured clinical interviews for DSM-IV depression in the context of cancer. Used in CALM study in Toronto, now expanding to Montreal for the DIRECT-sc study.*
2010 - present	Interprofessional DART Education on clinical response algorithms to emotional distress screening, targeting nurses, oncologists and patients, Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto *Multi-faceted knowledge translation approach with newsletters, patient awareness posters and signage, monthly clinic based seminars for feedback, interprofessional education seminars provided for clinic-identified topics of interest, production of a DART e-learning module, and development of a DART patient facing external website, as well as a DART educational intranet webpage with resource toolkits and referral resources.*
2010 - present	Clinical supervision of observers, medical students, psychiatry residents & clinical - Princess Margaret Cancer Centre, Faculty of Medicine, Dept. of Psychiatry, University of Toronto ***Clinical Fellows****: Abdullah Al-Ozairi, Peter Fitzgerald, Deborah Pink, Ahmad Alzahrani* ***Psychiatry Residents****: Marnie Howe, Judy Lin, Matthew Knox,*

Pracha Vatsya, Kavita Algu, Mara Silver, Abdul Al Humoud, Plabon Ismail, Michael Neszt, Joe Park, Abdullah Al Ozairi, Soraya Mumtaz, Tessa Wilson-Ewing, Paul Uy, Alexandra Cristian, Eloise Ballou, Sarah AlDerbas
***Elective Medical Students**: Angela Golas, Cedric Gabilondo, Rose Eckhardt, Saadia Sediqzadah, Arfeen Malek, Josh Weiss, Avni Pardasani, Claudine Davidson, Jennifer Teichman, Pamela Newman*
***Observers**: Claudia Del Vecchio, Maha Nasr, Chongya Niu, Danielle Rodin, Sabrina, Agnihhotri, Wyanne Law, Nardin Samuel, Gurneet Thiara.*

2009 - present — Differential Diagnosis of Low Mood, PGY4 Residents, Faculty of Medicine, Dept. of Psychiatry, University of Toronto
C-L Core Curriculum for Psychiatry Residents. Department of Psychiatry, University Health Network.Case based teaching on standard of care. Quarterly seminar. High evaluation scores.

2007 - present — Palliative Psychiatry Seminar, Multilevel Education, Faculty of Medicine, Dept, of Psychiatry, University of Toronto
Psychosocial Oncology, Princess Margaret. Weekly seminar series for medical students, residents and allied health staff featuring case based discussions and group debriefing/support in providing psychiatric care at the end of life. Highly rated seminar, increasingly attended by multidisciplinary staff.

2015 - 2016 — Management of Depression and Anxiety in Cancer for the DeSouza, Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto
https://portfolio.desouzainstitute.com/courseCodes/view/MDAC. E-learning course on screening, assessment and management of anxiety and depression in cancer patients. Highly reviewed with increasing enrolment.

2013 - 2015 — Inter-professional Model of Psychiatry Active Collaborative Care (IMPAC), Multilevel Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto
Collaborative care model embedding psychiatry residents in oncology clinics. Centre for Mental Health, Princess Margaret Cancer Centre. Providing indirect care and teaching first response to distress identified by distress screening. Highly rated by resident and staff satisfaction, significant improvement in staff comfort with responding to emotional distress.

2013 June 21	Making Every Encounter Therapeutic: A Psychosocial Oncology Workshop for Oncologists, Continuing Education, Faculty of Medicine, Dept. of Psychiatry, University of Toronto *Princess Margaret Cancer Centre. Workshop on communication skills, basic psychopharmacology and compassion fatigue prevention. Highly rated with multiple requests for delivery.*

H. Research Supervision

1. PRIMARY OR CO-SUPERVISION

Undergraduate

2017 Sept – 2018 June	**Primary Supervisor**. B. Sc. Bryan Gascon. *HMB399 senior year research project. Clinical response to suicide screening in DART.* Supvervisor(s). M. Li.
2017 June – 2017 Aug	**Primary Supervisor**. B. Sc. Bryan Gascon. *Two-Step Probabilities Approach for Depression and Anxiety Screening using the Distress Assessment and Response Tool (DART)*.
2014 Sep - 2015 May	**Primary Supervisor**. B. Sc. Chieh-Hsin Lee. *ANA498Y senior year research project. Longitudinal analysis of cytokines, fatigue and quality of life in AML patients.*
2014 Jun - 2014 Aug	**Primary Supervisor**. B. Sc. Caroline Saunders. *Constipation Screening in Cancer Patients*.
2014 Jun - 2014 Aug	**Primary Supervisor**. B. Sc. Chieh-Hsin Lee. *Psychometric Analysis of ESAS-r*.
2011 Jun - 2011 Aug	**Primary Supervisor**. B. Sc. Tamara Harduwar. *Cytokines, Fatigue and QOL in AML*.
2008 Jun - 2008 Aug	**Primary Supervisor**. B. Sc. Tania Panday. *Cytokines and Sickness Behaviours: A biological basis for depression in cancer*.
2007 Jun - 2007 Aug	**Primary Supervisor**. B. Sc. Danielle Rodin. *Traumatic Distress in High Risk Breast Cancer*.

2006 Jun - 2006 Aug **Primary Supervisor**. B. Sc. Danielle Rodin. *Psychoneuroimmunology and Genetics: A biological basis for depression in cancer?*.

Medical Students

2016 Jun – 2016 Aug **Primary Supervisor**. IMG CC3. Arjun Kundra. *Psychometric validation of GAD-7 and PHQ-9 in cancer*.

2013 Sep - 2014 Aug **Primary Supervisor**. CC2. Alexis Twiddy. *Determinants of Community Health Research Project: Impact of distress documentation by clinicians on quality of life, satisfaction with care and health outcomes*.

2012 Sep - 2014 May **Primary Supervisor**. CC2. Lindsay McColl. *Determinants of Community Health Research Project: Impact of the Distress Assessment and Response Tool (DART) on Patient Health Outcomes*.

2011 Sep - 2012 May **Primary Supervisor**. CC2. Joel Elman. *Determinants of Community Health Research Project: Improving the Usability of the Distress Assessment and Response Tool (DART) with a Two Step Approach to Screening*.

2011 Sep - 2012 May **Primary Supervisor**. CC2. Sean Crawford. *Determinants of Community Health Research Project: Investigating the Impact of the Distress Assessment and Response Tool (DART) on Patient Satisfaction and Quality of Life*.

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2010 Jun - 2010 Aug **Co-Supervisor**. CC4 CREMS. Filgen Fung. *Baseline cytokines, fatigue and quality of life in AML patients*. Supervisor(s): Dr. M. Li and Dr. S. Alibhai.

Postgraduate Students and Fellows

2018 Sept – 2020 Sept **Psychology Fellow**. Gilla Shapiro. *The Longitudinal Study of Medical Assistance in Dying (MAiD) in Patients with Advanced Canc*er. Supervisor(s): Dr. M. Li and Dr. G. Rodin.

2017 Sept – 2019 Sept **PGY 4 Internal Medicine**. Cassandra Graham.*The Longitudinal Study of Medical Assistance in Dying (MAiD) in Patients with Advanced Canc*er. Supervisor(s): Dr. M. Li and Dr. G. Rodin.

2018 July – 2018 Dec **International Research Fellow**. Sana Kazim. Psychiatry graduate from Jordan. *Impact of Screening for Distress on Psychosocial Oncology Care.* Supervisor: Dr. M. Li

2017 July – 2019 July **International Research Fellow**. Cristina Sade. Psychiatry graduate from Chile. *Longitudinal trends in cancer-related distress*. Supervisor: Dr. M. Li

2016 Jan – 2017 Jan **Postdoctoral Fellow**. Megan McCusker, Psychosocial Oncology. *Cytokines and Symptom Clusters in Ovarian Cancer.* Supervisor(s): Dr. M. Li and Dr. B. Haibe-Kains

2015 Sep – 2019 Sept **PGY2 Psychiatry**. Joshua Rosenblat, Clinician Scientist Program. *Intranasal Ketamine for Major Depression in Palliative Care*. Supervisor(s): Dr. M. Li and Dr. R. McIntyre.

2015 May - 2015 Aug **International Medical Graduate.** IMG research student. Gurneet Thiara, Psychosocial Oncology. *SRM mass spectrometry to identifying biomarkers of depression in cancer patients*. Supervisor: Dr. M. Li

2. OTHER SUPERVISION

Graduate Education

Thesis Committee Member

2018 – present **MSc Candidate.** Sumaya Dano, Institute of Medical Science - Department of Nephrology. Supervisee Institution: University Health Network. *Electronic Patient Reported Outcome Measures to Improve Pateint Centered Solid Organ Transplant Care*. Supervisor: Dr. I. Musci.

2008 - 2015 **PhD Candidate**. Joanna K Soczynska, Institute of Medical Science - Department of Psychiatry. Supervisee Institution: University Health Network. *Evaluating the Association between Cytokines, Insulin and Cognitive Performance in Euthymic Individuals with Bipolar I Disorder: A companion study to a randomized, double-blind, placebo-controlled, 8-week trial with Intranasal Insulin*. Supervisor(s): Dr. S. Kennedy and Dr. R. McIntyre.

2009 - 2011 **MSc Candidate**. Janet Ellis, Institute of Medical Science - Department of Psychiatry. Supervisee Institution: University Health Network. *Determinants of distress, referral to and utilization of psychosocial oncology services in patients with head and neck cancer*. Supervisor(s): Dr. G. Rodin.

I. Creative Professional Activities

1. PROFESSIONAL INNOVATION AND CREATIVE EXCELLENCE

2014 - present

New Models of Psychosocial Oncology Care at Princess Margaret. I have led the development of several innovative psychosocial oncology clinical programs to meet patient needs. These include the Inter-professional Model of Psychiatry Active Collaborative Care (IMPAC) program, the new development of an Alcohol and Substance Use Rehabilitation (ASURE) Team to manage cancer patients with co-morbid substance use disorders, and quality improvement projects such as the development of an E-cancer synoptic documentation system and database for clinic notes. These activities have led to my assuming leadership roles in administration of our clinical service, including quality oversight and management of critical incident case reviews.

2007 - present

Distress Assessment and Response Tool (DART) Program. Development of the DART emotional distress screening program, including psychometrics of screening tool selection, identification of optimal methods for implementation, training of clinicians in symptom intervention, evaluation of impact on clinical outcomes and knowledge translation for national and international uptake. DART is now the largest distress screening program in Canada and the most well established in the world, sustaining screening rates above the provincial standard of 70% for over 4 years. Positive impacts of DART on patient satisfaction with care, access to psychosocial services and improved ability to complete cancer treatment have been published. DART has been adopted for commercialization by the hospital, with growing international uptake across Canada, the United States, the Middle East, Germany, Italy and China.

2. CONTRIBUTIONS TO THE DEVELOPMENT OF PROFESSIONAL PRACTICES

2016 - present

Physician Lead, Medical Assistance in Dying, University Health Network.

I have developed a detailed MAID Framework and

operationalized the delivery of MAID at UHN. The framework includes a comprehensive education and training approach for all health care providers who may receive requests for MAID, and for the health care providers who will be involved in MAID assessment and intervention.

2012 - present

Inaugural Psychosocial Oncology Clinical Lead for the Toronto-Central South Local Health Integration Network and Provincial Psychosocial Oncology Program Committee Member.

Multiple activities in these roles have contributed to setting standards for the quality of psychosocial oncology care for cancer patients to reduce psychological morbidity and improve the patient experience.

3. EXEMPLARY PROFESSIONAL PRACTICE

2015 - present

CPA in Interprofessional Psychosocial Oncology Education

I have been invited to serve as the content expert in several interprofessional PSO continuing medical educational activites. In addition to my work developing staff training for DART and MAID, I developed the MDAC (management of depression and anxiety in cancer) e-learning course for the DeSouza Institute of continuing education for health care professionals, a webcast on the management of depression in cancer for the International Psychosocial Oncology Multi-Lingual Core Curriculum series. I have delivered many interprofessional lectures and workshops on PSO care and authored several textbook chapters and review articles based on my expertise in depression and cancer.

2011 - 2015

Development of Psychosocial Oncology in the Middle East.

Through consulting work with the University Health Network-Kuwait Cancer Control Centre (KCCC) Partnership, a psychosocial oncology program was established at the KCCC where none existed before. The impact of these efforts has been demonstrated by the successful establishment of a KCCC psychosocial oncology program, adopting the professional practice standards at Princess Margaret. Pilot implementation of DART screening in Kuwait has led to securing a national grant in Kuwait to ensure sustainability. The success of the Kuwait project has led to interest in the DART model, with further consulting work to start in the Hamad Medical Corporation in Doha, Qatar in the fall of 2016 and planned for Jordan in 2017.