# Thank God He Lived: Always, Do No Harm

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**Abstract**

**This paper critiques an expansion of Medical Assistance in Dying for psychiatric illnesses in Canada, utilizing Orlando Da Silva's memoir, *Thank God I Failed*, as a central case study. It argues that severe depression impairs cognitive autonomy, making consent impossible and exposing patients to structural coercion within an underfunded healthcare system. By analyzing the intersection of physical and mental suffering, the text challenges health system utilitarianism and the artificial segregation of pain. Ultimately, it calls for rigorous evidentiary standards in healthcare policy, emphasizing the system's fundamental obligation to protect vulnerable patients and prioritize comprehensive care over expedited assisted death.**

## Introduction

Bureaucracy, the German sociologist Max Weber wrote, gravitates toward utilitarian solutions (Weber 1968 [1921]). In no theatre of Canadian public life does this technocratic inclination expose itself more nakedly than in our oscillating romance with Medical Assistance in Dying (MAiD) for citizens whose sole underlying medical condition is mental illness.

Some argue that statutory frameworks never truly excluded psychiatric suffering, noting that semantic thresholds such as "incurability" and "foreseeability" yield to patient non-consent and actuarial frailty, respectively (Downie and Dembo 2016). Yet, policy arguments require real, breathing evidence of lives that may refuse to conform to a formulaic clinical taxonomy.

Orlando Da Silva delivers precisely this disruption in his memoir, *Thank God I Failed: A Lawyer's Suicide Attempt and the Case Against Trying* (Da Silva 2026). The book serves as a rigorous indictment of a healthcare state that substitutes the offer of a lethal alternative for the provision of actual care.

Da Silva subverts the Hollywood redemption narrative. He rejects the treacly presentation of a sanitized recovery from despair. His is a portrait of a self-made intellectual – a former president of the Ontario Bar Association, a senior Crown counsel and a federal political candidate – who mastered the performance of a trial lawyer's bravado while charting his own destruction following childhood abuse and, later, financial penury.

The book's title, with its failure confessional, registers with jarring force in each chapter. Corporate boardrooms fixated on metric optimization see "failure" as obscene. Yet, Da Silva demonstrates that his very survival stems from digressions from the norm: an estranged former spouse who refused to cooperate with his polite, self-harm persuasion; an emergency room psychiatrist who declined to accept his rationalizations; and a risk-containment system that accidentally granted him time (Da Silva 2026).

## Anatomy of Despair: The Grammar of Fear

Da Silva's narrative evokes William Styron's brilliant anatomy of despair, *Darkness Visible: A Memoir of Madness* (Styron 1990). Like Styron, Da Silva possesses the rare talent to describe the confinement of clinical depression from the inside. He traces its lineage to his childhood home on Weber Street in Kitchener, Ontario, a structure defined by burst pipes, crumbling floors and abrupt explosions of paternal fury. He recounts the moment when his older cousins tossed him off a second-floor balcony for their amusement, leaving him in the mud, teaching him the language of vigilance and silence.

"The body writes rules before the mind finds words," Da Silva writes, describing that day in 1970.

> I learned that danger could live inside a house and smile as it lifted you over the edge. I learned that the people you love can be the ones who drop you. I learned that if I appeared "calm" and asked for nothing, adults would remain comfortable.

This "grammar of fear" formed the foundation of a high-functioning career. It provides a stark insight for healthcare leaders: the behaviours we reward as signs of professional excellence – unwavering composure, a tireless work ethic and the

suppression of vulnerability – frequently mask the defence mechanisms of a fractured inner life. Da Silva ran for office, chaired boardrooms and won 32 out of 36 trials while privately planning the mechanics of suicide.

This specific professional identity as a seasoned trial litigator transforms the book's final movement into an eloquent legal brief against the expansion of MAiD. The legal critique arrives as an epilogue, forming the unavoidable conclusion of his memoir.

### Evidence, Cognition and the Burden of Proof

The core of Da Silva's argument, I feel, rests on his resolute understanding of credible evidence and the burden of proof. In December 2008, sitting in a student apartment on Old Carriage Drive, having consumed 180 sleeping pills and two litres of alcohol, Da Silva believed his disappearance constituted an altruistic necessity. He wrote with courtroom clarity that his death would offer his family the ultimate act of love.

Had a MAiD assessor met him during those weeks, Da Silva would have qualified as an ideal candidate under the proposed criteria for psychiatric euthanasia. He met the definitions of treatment-resistant depression, having tried more than 40 medications over 11 years; his suffering appeared severe, long-standing and irremediable. He possessed the legal acumen to present a rational, competent case for his own termination.

"What I needed then, and will likely need again," Da Silva warns, referencing the previously scheduled sunset clause for psychiatric exclusion in Canadian law, "is protection from my own certainty and ability to persuade."

Herein lies the central flaw of health system utilitarianism under MAiD: the illness hijacks the cognitive machinery required for autonomous consent. When severe depression grips the brain, memory acts as a selective archivist, erasing the recollection of wellness and presenting temporary agony as a permanent verdict. The mind lies and deceives and distorts, concocting a persuasive narrative of its own worthlessness.

Blessing a state-sanctioned mechanism of hastened death transmogrifies the state from a provider of care into a conspiratorial partner with the unrelenting disease of depression. It places an impossible evidentiary burden on clinicians to distinguish between an enduring desire to die and the cyclical distortions of a treatable affliction.

### Turn, as we must, to the highest laws of evidence

In criminal defence law, the state faces an enormous legal onus; it must prove its case beyond a reasonable doubt because the consequences of an error remain absolute and irreversible. If the state assists in ending the life of any citizen who is physically healthy but mentally broken, the onus must command equal severity. The state must prove that the desire to die exists independently of the illness that produces suicidal ideation.

### Structural Bankruptcy Versus the Cartography of Pain

Da Silva forces us to confront the structural odiousness of a healthcare system administering this regime. He reminds us that the options presented to patients exist within a real-world infrastructure starved for resources, access, quality, equity and basic human continuity.

Da Silva recounts his post-discharge experience in 2009. Having survived six months in a psychiatric ward, his progress relied on outpatient groups. Then, an unsigned notice appeared on the bulletin board: the groups faced cancellation due to funding reallocation. The system stranded him with self-renewing prescriptions and zero follow-up for the next two years.

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What moral right does a society possess to offer the certainty of death to its vulnerable citizens when it routinely denies them the sustained therapeutic infrastructure required to live with a shred of dignity and a chance at independence?

Following Da Silva to the edge of his argument forces us to confront another unsettling reality, one that breaches the walls the state erects between psychiatric and physical suffering. Healthcare systems artificially separate mental from physical pain as if managing a ledger. This clinical segregation distorts the mind-and-body duality that has influenced Western thought since René Descartes published his *Meditations on First Philosophy* (Descartes 1641).

Descartes cited the raw sensation of pain as the definitive proof that mind and matter intermingle. Anyone who has spent time at a hospital bedside knows physical and mental illness commingle, bleed into one another and twist into an agonizing knot.

When the body breaks, the mind quickly becomes an unreliable narrator of its own future. Yet our healthcare system treats the request for MAiD in physical cases with a breezy, procedural confidence, as if autonomous consent can be cleanly extracted from a body wracked by unalleviated torture. Just as our mental health infrastructure remains fractured and inaccessible, so too does the therapeutic architecture required to alleviate physical suffering.

### The Coercion of Infrastructure Fault Lines

We rush to offer the certainty of death to patients with degenerative diseases and chronic conditions while routinely denying them equitable access to advanced palliative care, proper pain medication options, affordable long-term care placements or the at-home care supports necessary to make life bearable. For many, the choice to die represents a fitful surrender to a system

that has made living financially and logistically impossible. When the state fails to provide the equitable infrastructure of care promised by the letter and spirit of the *Canada Health Act* (1985) and the *Charter of Rights and Freedoms* and of the Hippocratic Oath, the offer of an expedited exit ceases to be an act of mercy and becomes a form of structural coercion.

When an elderly patient can suffer cognitive decline from uncoordinated, cascading prescriptions, how can we pretend to possess the flawless administrative machinery required to safely adjudicate the termination of human lives?

We risk operating under a catastrophic hubris. We designed a lethal mechanism of state-sanctioned exit while leaving the actual framework of care to crumble under the weight of underfunding and administrative indifference. If we cannot manage the routine logistics of medication safety, how dare we claim the infallible diagnostic clarity required to declare a human life – whether broken in mind or shattered in body – permanently beyond redemption?

## Conclusion: The Sacred Obligation

The expansionist pro-MAiD movement achieves its legislative momentum through a narrative of advocacy disguised as an ode to autonomy and progressivism. Da Silva stands as a stubborn data point that thwarts this syllogistic reasoning. His survival proves that the vulnerable require protection from their own transient certainties rather than an expedited path to the exit.

We must recognize that when death becomes normalized as a standard clinical response to psychiatric distress, mercy quickly begins to look like efficiency. Those who have been conditioned by trauma or neglect to believe they represent an economic and emotional burden to their family will read the offer of MAiD as a state-sanctioned celebration of that falsehood.

Da Silva's memoir is a testament to the fact that we are all, regardless of our outward titles or our professional accolades, fragile. But that fragility is not an invitation for administrative erasure. It is an indictment of any health system that forgets its primary and unwavering obligation: to stay with patients in their journeys into darkness, to provide the time and the security they cannot find within themselves and to refuse to allow them to disappear. HQ

## Always, do no harm

*Thank God I Failed* represents a vital intervention into a debate that will define the moral character of our time (Da Silva 2026). We must thank God the author lived, because his survival preserved the voice needed to save our health systems from a heartless, utilitarian illogic.

## References

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