Toronto General Hospital
University Health Network

James Downar, MD(CM), MHSc, FRCPC
Intensive Care and Palliative Care, University Health Network
Assistant Professor, Dept of Medicine, University of Toronto

Standing Committee on Justice and Human Rights
Chambre des communes | House of Commons
131, rue Queen, 6-07| 131 Queen Street, 6-07
Ottawa, Ontario K1A 0A6
Tel. (613) 996-1553
JUST@parl.gc.ca

April 27, 2016

RE: Submission to the Standing Committee on Justice and Human Rights re: Bill C-14

Dear Mr. MacPherson,
I would like to thank the Committee for seeking my input on Bill C-14. I appreciate the Government's efforts to craft a bill that balances multiple concerns while addressing a controversial issue. However, I am concerned that bill C-14 will not meet the needs of Canadians, and will lead to potentially undesirable consequences. I will highlight 3 specific concerns:

A. A "reasonably foreseeable" death.
Summary and Suggestion: Criterion 241.2 (2) (d) should be removed from Bill C-14. The term "reasonably foreseeable" is subjective, and does not clarify the existing definition of "grievous and irremediable medical condition". Depending on how it is interpreted, it could lead to serious consequences for well-intentioned physicians, or to the Supreme Court striking down the new law.

The proposed section 241.2 (2) defines a grievous and irremediable medical condition. Criterion (d) specifies that "their natural death has become reasonably foreseeable…." The term "reasonably foreseeable" is vague and could be interpreted differently by reasonable people. On one hand, a physician could reasonably state that every living person has a foreseeable death. This is particularly true for anyone who has a serious and incurable illness, and who is in an advanced state of irreversible decline in capability (criteria (a) and (b)). Interpreted literally, criterion (d) adds nothing to the bill. On the other hand, a reasonable person could also interpret criterion (d) to mean that the patient must have some form of terminal illness in order to be eligible. This interpretation could lead to 3 serious consequences:

1. The law could be applied inconsistently, leading to differential access for some cases.
2. Authorities tasked with overseeing Medical Assistance in Dying could interpret criterion (d) more narrowly than some practicing physicians, leading to professional or legal sanction for well-intentioned physicians who thought that they were following the

Toronto General Hospital
University Health Network

James Downar, MD(CM), MHSc, FRCPC
Intensive Care and Palliative Care, University Health Network
Assistant Professor, Dept of Medicine, University of Toronto

rules. This will have a profoundly chilling effect on the medical profession as a whole, leading to a reduction in access.

3. The Supreme Court of Canada's ruling referred to a patient (Kay Carter) who did not have a terminal illness, and it pointedly did not limit its decision to cases of terminal illness. Since criterion (d) could reasonably be interpreted by physicians or the courts as implying that Medical Assistance in Dying should be limited to terminal illness (however defined), then the Supreme Court of Canada will likely strike down this provision or the law itself. The impact on patients, family members, and healthcare workers of restarting the process of developing a legal framework would be significant.

B. The lack of specific elements for improving Palliative Care.
Summary and Suggestion: Add a provision to C-14 mandating the creation of a Canadian Palliative Care Secretariat no more than 12 months after it becomes law.

Reports from the Federal and Provincial/Territorial Expert Advisory Panels, as well as the Special Joint Committee on Physician-Assisted Dying, have all highlighted the need to make substantive improvements in the availability and quality of Palliative Care for all Canadians. Even the preamble of bill C-14 indicates that "the Government of Canada has committed to develop non-legislative measures that would support the improvement of a full range of options for end-of-life care".

These measures need not be limited to non-legislative measures. The federal government can re-establish the Canadian Palliative Care Secretariat, as recommended by the Special Joint Committee, with a mandate to establish national standards for palliative care resource availability and research. The best way to ensure that this happens is to include it in the bill.

C. **Exclusion of mature minors**
Summary and Suggestion: Revise section 241.2 (1) (b) to read: "they are capable of making decisions with respect to their health." There is no ethical or legal justification for limiting the provision of Medical Assistance in Dying to adults.

The main rationale for allowing Medical Assistance in Dying, which is the recognition that some types of suffering cannot be treated, and that people should be allowed to forego some quantity of life in the interest of quality of life, is as true for children as it is for adults. We already allow mature minors to make many medical decisions (including life-and-death decisions). The eligibility to make decisions is based on capacity rather than chronological age. The Provincial/Territorial Expert Panel and Special Joint Committee on Physician-Assisted Dying both recommended a provision to allow mature minors access to Medical Assistance in Dying, and it is hard to see how this restriction would survive a challenge to the Supreme Court of Canada.

Toronto General Hospital
University Health Network

James Downar, MD(CM), MHSc, FRCPC
Intensive Care and Palliative Care, University Health Network
Assistant Professor, Dept of Medicine, University of Toronto

Respectfully yours,

James Downar, MDCM, MHSc, FRCPC
Divisions of Critical Care/Respirology and Palliative Care, University Health Network
Assistant Professor, Department of Medicine, Faculty of Medicine, University of Toronto
Program Director, Conjoint Residency Program in Palliative Medicine, University of Toronto
Chair, Postgraduate Education Committee, Canadian Society of Palliative Care Physicians
Chair, Clinical and Ethical Affairs Committee, Canadian Critical Care Society