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Standing Committee on Justice and Human Rights

Dear Members of the Committee

Proposed Amendments:

- 1) Any request for Physician Hastened Death (PHD) should be evaluated by a centralized, multi-disciplinary team of highly trained professionals *before* PHD is undertaken.
- 2) No health care professional or institution should be compelled to participate in any aspect of PHD. Criminal sanctions should be written into Bill C-14 that would apply to those coercing participation either directly or by imposing sanctions or withholding employment or education from those who refuse to participate in PHD.

The Canadian Society of Palliative Care Physicians uses the term Physician Hastened Death (PHD) to refer to assisted suicide and euthanasia. Palliative care provides medical aid in dying without hastening the death of any patients. In the interest of clarity, the term PHD will be used in this document.

PHD is being introduced into Canadian society as an exemption to the criminal code's prohibition against culpable homicide. Therefore, the federal government has both the jurisdiction and the responsibility regulate and to monitor this exemption in ways that will provide protection for citizens who are vulnerable. The *Carter* decision itself included a recommendation for "a carefully-designed system that imposes strict limits that are scrupulously monitored and enforced."ⁱ

For the past twenty-seven years I have practiced in Canada as a palliative care physician. Palliative care is an essential service for vulnerable patients and families facing serious illnesses, and yet the 2011 Parliamentary Committee on Palliative and Compassionate Care reported that only 30% of Canadians have access to adequate palliative care. I serve as an advisor for the Vulnerable Persons Standard (VPS)ⁱⁱ, and commend it to you in its entirety. It was established with input across many sectors in Canadian society and has a broad base of support. One of the pillars of the VPS is an effective evaluation process *before* the PHD occurs. The first amendment above would work toward that goal. Palliative care is never practiced by physicians alone; a team is essential to proper care. Requests for hastened death are extremely complex and should be evaluated by a team of

trained professionals as well. Their mandate would be to explore these requests and to identify any aspects of the request that would be amenable to treatments acceptable to the patient but not yet implemented, or that stem from a lack of proper social supports. This need not be onerous or complicated. PHD is a serious, irreversible procedure and it is important that it is not undertaken without proper oversight. A centralized evaluation team would have additional benefits. Patients could self-refer to such a service and this would not only provide direct access to PHD, but would avoid difficulties involved when health care professionals choose not to participate in PHD due to clinical judgment or conscientious objection. A centralized system could also provide a better opportunity to monitor and to study all aspects of PHD and to modify regulations and procedures if problems are identified. This central system could be available by teleconference for remote areas, or teams could travel to remote communities as needed.

There has been an almost fanatical emphasis on “access” to PHD for anyone who wants it, almost for any reason, and too little attention paid to the real harm that will result from patients’ and families’ legitimate fears and subsequent avoidance of care. There are many Canadians who want absolutely nothing to do with PHD and who are fearful that they may have their deaths hastened without their consent—not an unreasonable fear if one considers studies from Belgium and the Netherlands where 25-30% of euthanasia deaths occur without patient consent.^{iiiiiv} These fears have an enormous impact on patient care. I remember very vividly, especially during the early years of my palliative care practice, that many patients and families would refuse to see us as consultants and that some colleagues would refuse to refer patients to us because of the perception that we represented “Dr. Death” and would hasten patients’ deaths. This was tragic and continues to some extent even today. We know that we have tremendous relief to offer to patients and families on so many levels and it is very distressing to think about regressing to those days when our assistance was avoided.

An additional safeguard that could assuage some of these fears would be to require that PHD be carried out only in separate facilities that are regulated by the federal government and are not associated with the regular health care system. These separate spaces would not overly inconvenience anyone seeking PHD and could include the patient’s home or mobile units, such as British Columbia’s mobile mammography vans. In addition, both institutions and health care professionals must be allowed to opt out completely from any participation in PHD without fear of repercussions or sanctions of any kind. (See amendment 2 above.) This would provide “euthanasia-free zones” or safe spaces that are every bit as much a right for patients who want to be safe from possible non-consensual PHD as “access” is for those who wish to have PHD. It is interesting that there are many, many services for which patients have to travel some distance, such as radiotherapy, dialysis, specialized surgeries, and even some forms of medical imaging such as MRIs and there is no equivalent outrage at the thought of limiting access to those important services for patients. Access to even basic palliative care is not yet mandated, and it seems ludicrous to mandate access to PHD without first mandating *and funding* proper access to palliative care for all Canadians. In addition, patients should have the opportunity to choose to be treated by physicians and other health care professionals who have made principled, firm commitments to avoid all participation in PHD. This is

the Hippocratic ethic that has informed medicine for over 2,400 years and reassures patients, instilling hope and generating trust. It is disingenuous to assert that an “effective referral” does not make a physician complicit in PHD when referrals for unacceptable practices, such as female genital mutilation, are considered to be complicit. Even in non-medical law referral is culpable—referring someone to a “hit man” when asked to suggest an assassin is considered being an accessory to murder. Also, Canada as a country does not “refer” for capital punishment since we will not extradite a criminal accused of a capital offense to a jurisdiction that has the death penalty without written assurance that the death penalty will not be applied. Physicians with individual patients who are being asked to refer to specific physicians who will carry out the PHD are obviously more complicit than either of those scenarios. It is also noteworthy that in those jurisdictions where PHD is legal there has been no need for coercion of either institutions or individuals to participate and access has not been impeded.

It is the responsibility of the federal government to consider the safety and protection of all citizens, especially those most vulnerable. At the very least, federal oversight should include the adoption of the Vulnerable Persons Standard with an emphasis on prior review of every case by a multi-disciplinary team *before* PHD is carried out; the protection of conscience for those institutions and health care professionals who wish to opt out entirely; and the continued prohibition of PHD for children, those with psychiatric illnesses alone and by advance directive. Stronger protection for vulnerable citizens would be possible if PHD is carried out only in facilities that are entirely separate from the regular health care system.

Thank you very much.

Sincerely,

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ⁱ *Carter v. Canada (Attorney General)*, 2015 Supreme Court of Canada 5. paragraph 27.

ⁱⁱ www.vps-npv.ca/

ⁱⁱⁱ Chambaere, K. et al: "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" *CMAJ* 2010; 183: 895- 901.

^{iv} Chambaere, K. et al: "Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium." *NEJM* 2015; 372:1179-1180.