May 2, 2016

Greffier du comité | Committee Clerk
Comité permanent de la justice et des droits de la personne| Standing Committee on Justice and Human Rights
Chambre des communes | House of Commons
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Dear Mr. MacPherson,

Please accept my brief as a submission to the committee reviewing Bill C-14 related to medical assistance in dying. I write to you as a psychiatric nurse whose clinical experience with people affected by schizophrenia spans more than forty years. I also write as a family member of people with various disabilities, one of whom will never be able to walk, talk, perform his own personal care, or be capable of consent. While I strongly oppose any criteria that qualify people for induced death, I urge you to make three amendments to Bill C-14.

First, remove plans stated in the preamble to explore access to assisted death for minors, people incapable of consent at the time of the lethal dose, and people where mental illness is the sole underlying medical condition. Second, develop robust criteria to monitor requests for assisted death before the act can be carried out, and remove proposed amendments that 1) prevent investigation of deaths for inmates who meet Bill C-14's criteria or 2) deceptively identify the cause of death for veterans as the underlying condition, rather than the lethal dose. Third, protect by legislative means not only medical and nurse practitioners who perform assisted death, but also health professionals and institutions that object to participating in assisted death directly or indirectly for reasons of conscience. Unlike non-legislative measures, this will standardize robust protection for conscientious objectors across Canada, and provide a safe haven for patients and families who do not want assisted death.

The first amendment I propose for the preamble reduces the risk that highly vulnerable groups will be coerced to request assisted death, or that others will do so on their behalf. In my clinical experience, the burden of illness increases for clients with severe and persistent mental illness because as Canadians, we provide them with inadequate and at times unsafe housing; insufficient financial support for food and a decent quality of life; and poor access to timely mental health services or ongoing case management. How can we say that people in these circumstances could make a free choice that death is better than the suffering they endure? This situation parallels the choice people make for assisted death when palliative care services are unavailable; in effect, we coerce people to choose death by the suffering we require them to endure due to the circumstances we place them in.

The second amendment that I propose relates to sections 241.31 (3), where the Minister of Health may make regulations to monitor assisted death. Monitoring systems that depend on a practitioner's self-report are flawed; in Belgium in 2007, for example, only 50% of euthanasia cases were reported, according to a survey of physicians who signed death certificates. Most of the unreported cases did not have the required documentation, and most lethal injections were administered by a nurse. I propose that you mandate a monitoring system that requires review of requests for assisted death from the time they are registered to qualify the person for the procedure, as is currently done

with the superior courts during this period when the implementation of *Carter* remains suspended. Please note that in the current bill, medical or nurse practitioners are not required to administer or be present for lethal doses of medication. Effective monitoring will require persons reporting on the procedure to be present at the time the medication is ingested or injected, yet this is not required in sections 227 (1) through 227 (3). Abuses discovered after the fact are ineffective in protecting the patient who died. However, data from any monitoring system such as the one I propose (seen currently with the superior courts) needs to be tracked and the findings implemented to ensure that practices follow the law and related regulations. Canada has a system for monitoring health care assessments and practices through CIHI.

Third, legislated protection for individuals and institutions that cannot participate directly or indirectly in assisted death needs to be a priority at the federal level to standardize conscience protection across Canada. I recommend that this legislation make it clear that conscientious objectors may continue to provide health care unrelated to the person's request for assisted death until other care can be arranged. However, it must also be clear that a conscientious objector is not required to make a referral to another care provider to facilitate death.

The Carter decision and Bill C-14 radically undermine the goals of health care, which are to promote the health and optimal function of the client. Unfortunately, the Quebec experience of professional confusion about the obligation to preserve life for vulnerable, stigmatized populations who have not formally requested assisted death, such as those with mental illness or physical disabilities, is not an isolated example. Please consider my proposals to enhance safeguards for vulnerable populations. Based on international experiences with euthanasia, it will be extremely hard to protect our vulnerable patients and family members.

Sincerely,

Helen McGee, RN MN
Advanced Practice Nurse