Medical Assistance in Dying:
A *Private Request*, a *Public Act*

Proposed Amendments to Bill C-14

A Brief
Submitted to
House of Commons Standing Committee on Justice and Human Rights
by
Canadian Association for Community Living (CACL)

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The Canadian Association for Community Living is a national federation of 40,000 members, 300+ local and 13 provincial/territorial associations assisting people with intellectual disabilities and their families. We share information, foster leadership for inclusion, engage community leaders and policy makers, seed innovation and support research. We seek to attain full participation in community life, end exclusion and discrimination on the basis of intellectual disability, promote respect for diversity and ensure human rights and equality for all Canadians.

Introduction

Medical assistance in dying will soon be a publicly funded and regulated service in Canada, designed to bring about the death of eligible persons. Under C-14, those delivering the services would be protected from criminal liability for culpable homicide or aiding a person to die by suicide, provided they act in accordance with legislated eligibility requirements and safeguards.

This will be an entirely new public service system in Canada, its policy goal never before entertained under federal criminal or health law in this country. It will launch within just five weeks even though its design is far from finalized. This fact, combined with growing evidence that similar public services in other countries do not have adequate safeguards in place to protect vulnerable persons, suggests that extreme caution must be exercised. Fair access must be enabled, while guarding against well-known risks of inducement under such systems.[1]

CACL very strongly supports restricting access as proposed in Bill C-14, to those whose natural death is reasonably foreseeable. This restriction has been found to be consistent with the *Carter* decision and the *Charter* (see Brief to this Committee by constitutional law expert, Dianne Pothier). Including mental conditions that cause suffering, as a sole criterion for access, will inevitably lead to trends we are seeing in Belgium and the Netherlands – with people with intellectual disabilities, autism and various mental health conditions being euthanized.[2]

We believe that a public service designed to terminate people's lives on this basis is both repugnant and dangerous. It will place at fundamental risk: 1) those who will be subject to the inevitable abuse and error leading their requests being approved; and, 2) those who will request this service because of the psychological suffering and self-stigma that will result from their medical or disability-related conditions becoming a publicly sanctioned reason to have a life terminated. Restricting access to this group does not mean their suffering is any less deserving of public attention. Rather, it simply means that as a society we do not accept that their conditions should be considered causes of death or reasons to die. The system should be designed for those who are dying and who are experiencing intolerable suffering.

Below, we recommend specific amendments to Bill C-14. The current system for authorizing requests by decision of a superior court should remain in place unless the proposal for review tribunals presented by David Baker and Gilbert Sharpe can be implemented, or until further study of other options. The Supreme Court established this system to be compliant with *Carter*. Amendments are needed to ensure the *Criminal Code* standard for informed consent is consistent with *Carter.* Independent assessment of vulnerability is required as physicians and nurse practitioners are not trained in this area. To address this gap, we propose that all patients who are dying and who request MAID should be provided - at a minimum - a palliative care consultation'. Amendments are also proposed for information collection and reporting in order to fulfill the purposes in the Preamble.

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[1] For a recent review of evidence, see Canadian Association for Community Living, Assessing Vulnerability in a System for Assisted Death in Canada (2016) online: http://www.vps-npv.ca/news-and-resources.

[2] Scott Y.H. Kim, Raymond G. De Vries and John R. Peteert (2016) Éuthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014", *Journal of American Medical Association – Psychiatry*.

A. Preamble: Proposed addition

Whereas the Government of Canada recognizes its constitutional obligations to protect the vulnerable from error and/or abuse in medical assistance in dying, in fulfillment of those obligations commits to examining with Provinces and Territories a range of options for independent, prior authorization of requests for medical assistance in dying;

B. Eligibility for medical assistance in dying

***Current* 242.2 (1)**	***Proposed* 242.2 (1)**
(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and	(d) they have made a voluntary request for medical assistance in dying that, in particular, is not affected by inducement, undue influence, coercion or external pressure; and,

C. Safeguards

241.2 (3)(a) to (f)… as is; Proposed new subsection: (g) and (h)
Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must… (g) confirm that a qualified clinician, without any other role in considering or administering medical assistance in dying for that person, has: (i) provided the person with a palliative care consultation outlining the full range of treatment, technology and support options that might alleviate suffering and any vulnerability to inducement to commit suicide, and has attested that the person understands information relevant to using those options and appreciates the reasonably foreseeable consequences of a decision or lack of decision to use those options, thus establishing that the person has made an informed decision in this regard; and (ii) provided the medical practitioner/nurse practitioner with a written palliative consultation report identifying the person's sources of suffering and any vulnerability to being induced to commit suicide; the options considered through the consultation; the clinician's assessment of the person's capacity to provide informed consent to use the options; and reasons the person did not use the options in the circumstances.
(h) refer the patient to specialized counseling if either medical practitioner/nurse practitioner is of the opinion that the capacity of the patient, and/or the voluntariness of the patient's consent, may be compromised by, for example: a mental health condition; inducement, undue influence or coercion.

D. Prior review by superior court: Proposed new Section: 241.21

Before medical assistance in dying is provided, a person must apply to the superior court of their jurisdiction for a confirmation that

(i) the person is making a valid and voluntary request,
(ii) meets eligibility criteria set out in section 241.2(1) and (2), and
(iii) that the safeguards set out in section 241.2(3) (a) through (h) inclusive [as proposed above] are fully satisfied.

E. Regulations

***Current* 241.31 (3)**	***Proposed* 241.31 (3)**
The Minister of Health may make regulations	The Minister of Health **shall** make regulations that shall come into force on the day that this law comes into force, and may make regulations subsequent to that date as determined by the Minister,

Proposed new sub-section: (3) (a) (iv)

at a minimum, the information shall include

a. socio-demographic information about all persons requesting medical assistance in dying,
b. the grievous and irremediable medical condition for which such assistance was sought,
c. whether it was this condition or other circumstances or conditions which led the medical/ nurse practitioner to the conclusion that the person's natural death had become reasonably foreseeable and, if the latter, what those circumstances or conditions were,
d. nature of the person's suffering and any vulnerabilities to inducement to commit suicide,
e. the reasons for the person's request,
f. options proposed or provided to alleviate the person's suffering,
g. the results of the palliative care consultation,
h. whether or not the medical practitioner / nurse practitioner found the person could provide informed consent to medical assistance in dying, and
i. whether the person chose medical assistance in dying and, if so, the form of assistance;

F. Report on medical assistance in dying in Canada

Proposed new section: 241.32

The Minister of Justice and the Minister of Health shall jointly cause to be tabled in each House of Parliament, on an annual basis, a report on the system of medical assistance in dying as it is being implemented in Canada, and which shall include:

(a) an aggregate analysis of the information pursuant to section 241.31(3)(a)(iv) and
(b) legal, policy and ethical issues that analysis raises in relation to the principles, values, rights, obligations and concerns as laid out in the preamble to this law, in particular:
  (i) fair access to medical assistance in dying,
  (ii) effectiveness in protecting vulnerable persons from abuse/error,
  (iii) impact on perception of persons who are elderly, ill or disabled,
  (iv) impact on the health professions, integrity of the health care system, and Canadians' trust in the health care system,
  (v) progress in improving the full range of options for end-of-life care, and
  (vi) any other matters identified through the analysis of information collected.