

Introduction

I am a family physician at St. Michael's Hospital and Surrey Place Centre, Toronto, and an Associate Professor in the University of Toronto's Department of Family and Community Medicine. In my practice, I provide primary care mostly to people who are elderly and people with developmental disabilities. I also serve as the director of the Developmental Disabilities Primary Care Program (DDPCP), which is funded by the Government of Ontario to develop evidence-based guidelines, resources, and training to improve the primary care of adults with developmental disabilities.¹ I am the current Chair of the Committee on Ethics of the College of Family Physicians of Canada (CFPC) and have served as Chair of the CFPC's Task Force on End-of-Life Care, which produced *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (2015).² While I am not representing these organizations, I will draw on the CFPC's *Guide* and on my experience helping to develop guidelines for the primary care of people with developmental disabilities.

Preamble of Bill C-14

I fully support the statements that “it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled”; that “vulnerable persons must be protected from being induced, in moments of weakness, to end their lives”; and that “suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities.”

I understand that Bill C-14 is intended to amend the *Criminal Code of Canada*. However, if the Government of Canada wishes to “avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled”, and continues to recognize that “suicide is a significant public health issue”, then people who are rendered vulnerable or at risk by decriminalization of medical assistance in dying should be assured of concrete, practical alternatives, such as access to assessments, care and supports that they require. Their right to these should be recognized in Bill C-14.

Moreover, for many Canadians, trust in their provider of health care is important. They should be assured of supportive environments and safe havens of care in which assistance in dying is excluded. The principles set out in the *Canada Health Act*—public administration, comprehensiveness, universality, portability and accessibility—should be applied equitably to the health care of these Canadians also in Bill C-14.

For these reasons, I suggest an addition to the Preamble of Bill C-14 affirming that *it is important for persons to be assured of and to have access to the best possible assessments, care, and supports that they need, including excellent palliative care and suicide prevention, and the option of being cared for in facilities and other supportive environments in which medical assistance in dying is excluded.*

This affirmation would require amendments to certain other parts of Bill C-14:

241.2 (1) Eligibility for Medical Assistance in Dying

Unaddressed compromised mental health, such as depression, anxiety, or some personality disorders that render a person less able to cope with transient or modifiable environmental and inter-personal stresses can diminish both the voluntariness of a decision for medical assistance in dying and the stability of such a decision. Compromised mental health is very common in people who are elderly, those who live with neuro-cognitive and other complex medical conditions, and those who have a developmental disability, but its manifestations can be difficult to detect without expertise. Those who have a “grievous and irremediable medical condition”, as defined in 241.2 (2) of Bill C-14, are not exempt from being affected by compromised mental health that can be addressed.

Existential distress, such as the loss of hope or meaning, the sense of losing one's dignity and worth, the feeling of being a burden to others, and being lonely, in persons who consider or request medical assistance in dying can often be addressed by holistic health care, social and spiritual supports. Existential distress can often go unnoticed by health care providers or addressed inadequately or inappropriately.

In people with developmental disabilities also, distressed behaviours, whether existential or due to transient and modifiable environmental and inter-personal stresses, can often be difficult to interpret and assess by health care providers who are unfamiliar with caring for them.

I therefore suggest amending the eligibility criterion in 241.2 (1) (d) of Bill C-14 to read: "they have a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure *or compromised mental health or distress that can be addressed.*"

I also suggest adding a new stipulation: "*their request for medical assistance in dying is clear and resolute and that, in particular, it was not made due to compromised mental health or distress that can be addressed.*"

241.2 (3) Safeguards

For reasons given above, the absence of any requirement for inter-disciplinary assessment of people requesting medical assistance in dying, such by those with expertise in palliative care, psychiatry, developmental and other disabilities, or spiritual care as needed, is concerning. Also concerning is that, under the current version of Bill C-14, the independent *confirmation* of a person's eligibility for medical assistance in dying by a second medical or nurse practitioner does not explicitly require an independent *assessment* of that person. And, although giving informed consent to receive medical aid in dying is an eligibility criterion in 241.2 (1) (e), there are no safeguards to ensure that adequate information has been given to the person and opportunities for discussion regarding the clinical and ethical implications of all options, including alternatives to medical assistance in dying, such as palliative, hospice or other care.

I urge that the following amendments to Bill C-14 241.2 (3) be considered:

- That both the attending and independent medical or nursing practitioner should separately examine and assess the person requesting medical assistance in dying and the person's health records;*
- That both assessors should be familiar with end-of-life care and the biomedical, psychological, and developmental issues relating to the person's health condition(s).*
- That at least one assessor should have expertise in mental health assessments, including assessment of suicidal behaviours;*
- That both should be satisfied that adequate information has been given to the person and opportunities for discussion regarding the clinical and ethical implications of all options, including alternatives to medical assistance in dying, such as palliative, hospice or other care.*
- That, where there is doubt in either of the assessors, or a dispute between them, regarding a person's eligibility for medical assistance in dying, referral should be made for a judicial review, which may require further assessments or the lengthening of the waiting period of 15 days.*

For the protection of people rendered potentially vulnerable in the decriminalization of medical assistance in dying, there are other aspects of this version of Bill C-14 that are important to consider:

241.31 Filing Information

Transparency in the implementation of Bill C-14 is vital. Provisions requiring accurate documenting and reporting of medical assistance in dying in Canada, and public access to this information, should be ensured in this legislation rather than left open as regulations that the Minister of Health "may" make.

While the details of regulations can be worked out in time, I urge that these basic principles guiding the development of regulations be made in Bill C-14 241.31:

- That the Minister of Health **should** (rather than “may”) make regulations “respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying” in Canada.
- That such information should be made publicly available.
- That medical and nurse practitioners be required to certify medical assistance in dying as the cause of death in addition to the person’s medical condition.
- That a report should be made of every instance of medical assisted dying.

241 (3) and 241 (5) Exemption for person aiding practitioner and for person aiding patient

I submit that both of these exemptions should be removed from Bill C-14. They go beyond what is required by the *Carter v Canada* decision, are not necessary, and because of the open-endedness of the term “person” (i.e., any person), medical assistance in dying would be difficult to regulate with the aim of limiting abuse and protecting vulnerable persons.

Conclusion

The Parliament of Canada is tasked with proposing a regime for the regulation of medical assistance in dying but it must ensure that it also protects vulnerable Canadians. Any legislation decriminalizing medical assistance in dying, as required by *Carter v. Canada*, should promote appropriate and robust assessment of persons making requests for medical assistance in dying, safeguards to ensure that Canadians who would benefit from mental health, palliative, hospice and other care that they need receive that care, transparent and public documentation of medical assistance in dying, and protection for Canadians who wish to receive care from facilities and other supportive environments that do not offer medical assistance in dying. The above considerations and proposed amendments to Bill C-14 are offered to improve the provisions in the Bill in ways that address these important and justified concerns.

Thank you for considering this brief.

Sincerely, 

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¹ <http://www.surreyplace.on.ca/resources-publications/primary-care/>

² http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Guidefor%20Euthanasia_EN_Final.pdf