

Medical Assistance in Dying

Submitted by Colette Squires, M.A. (Criminal Justice)

Proposed changes:

1. **Preamble:** The rights of the individual have been well-represented in this legislation, undoubtedly a favourable response to Dying with Dignity Canada and others who champion an individualistic, rights-based worldview. However, as a democratic society **we are also guided by a collective will to look out for the vulnerable, and to promote human thriving and wellbeing. This transcends the individual and speaks to the need for our government to work for the wellbeing of all, through providing appropriate supports, programs, assistance, and other mechanisms to improve the lives of Canadian people.**

In this regard, this legislation is problematic. A healthy society cannot be built solely on the rights of the individual. We share our burdens collectively and we care for people in need: that is why we have a social safety net and why we pay taxes. The problem with an exclusively rights-based framework for this legislation is that it does not include our collective responsibilities toward one another. It does not strongly state that this is an absolute last resort that should be avoided if at all possible.

Recommendation: Include content that reflects the government's collective commitment and responsibility to the health and wellbeing of Canadians as a first priority, and the Canadian values around providing the best possible health care to advance the quality of life, not the promotion or advancement of death. This is necessary to provide support for increased hospice care, improved mental health services, stronger commitment to medical research, and the prevention of a utilitarian approach that would favour euthanasia or suicide as more cost-efficient than providing health care.

2. **Eligibility for medical assistance in dying: (b)** they are at least 18 years of age and capable of making decisions with respect to their health;

Given that the human brain does not fully develop until a person is approximately 23 – 25 years of age, and executive function and decision-making capacities of the brain are the last to fully form, it is inadvisable to provide this service to people who are younger than the age of 23. The age of adulthood as 18 was determined from a political perspective, not from a biological one.

Second, we should do everything possible to help young people recover their health, not advance their death. We need to increase the medical supports necessary to diminish the perceived need for young people to want to end their lives. Our young people are our future. We need to learn from the advancement of euthanasia in Holland and Belgium, which has now led to babies and children being euthanized – and ensure our laws prevent us from going there.

Recommendation: change the age of eligibility to 23

3. Section 3: Safeguards

Independence of the two medical professionals: Given that medical professionals are frequently wrong about a patient's expected life span, they generally work apart from other social services or supports, and they often develop a certain dispassionate approach to protect themselves from compassion fatigue or the emotional impacts of observing traumatic situations day-in-day-out, **it is recommended that the review of eligibility be multi-disciplinary, rather than just controlled by medical professionals.** Over time it is very possible that new cohorts of doctors will be quite comfortable with ending a patient's life, especially if those who object for reasons of conscience have been marginalized or forced out of the field. Therefore, it is important to have other team members who can fully and holistically assess if everything possible has been done for that patient – especially since feeling hopeless, depressed and wanting to die can be present if other supports are lacking. These multi-disciplinary team members would be completely independent because they would have no capacity to participate in ending another person's life, whereas doctors and other medical practitioners will be able to directly participate, and financially benefit, from providing assistance to end someone's life. **It is hoped that the use of this legislation would be very rare.** Do not make it easy for pro-euthanasia/pro-assisted suicide medical practitioners to advance the "slippery slope" towards widespread normalization of this practice as has occurred in Belgium and Holland.

Recommendation: Cases should be reviewed by a multi-disciplinary team that holistically assess the patient's situation. Doctors who will be participating in the process should not be part of this review, since they will ultimately receive financial gain, and may be biased towards physician-assisted death.

4. Waiting period of 15 days, especially those with mental illnesses:

Given that mental health treatments and supports are still in their infancy in Canada and much has yet to be accomplished to achieve nation-wide excellence in mental health care, it is inadvisable to provide physician assisted dying to those with mental illnesses. Instead, we should be focusing our efforts on improving treatment and research. Currently, psychiatric care primarily provides treatment through drugs, and the effectiveness of a given drug for a particular patient can currently only be determined by trying the drug to see if it works. It takes at least 3 weeks for the drug to reach therapeutic levels, and then longer to assess if it's a right fit for the patient. If not, then the doctor will try something else until, finally, they feel they have hit on the right medication for that patient. We do not yet have the means to determine in advance of treatment what exactly the patient needs so that this trial-and-error approach can be avoided. Currently, drugs are over-prescribed, waiting lists to see psychiatrists are long, and access to counselling and/or therapy remains the luxury of those with financial resources. Providing physician assisted dying to those with mental illnesses is a sign of our failure to provide what these people need.

Recommendation: Clarify the eligibility requirements to disallow those with mental illnesses from access. Less desirable: If they must be included, then increase the waiting period for those with mental illnesses to a longer time period.

5. **Signatories and Witnesses:** It is of great concern that someone as young as 18 could be asked to sign or be a witness especially given the maturation of the human brain at age 23 – 25, and that a person needs a very nuanced understanding of the issues to provide reasonable judgment on the matter. Human decision-making does not fully mature until the age of 23 -25.

Recommendation: Witnesses and signatories should be at least 23 years of age.

6. **Destruction of Documents:** It will be very important to adopt an evidence-based approach, with monitoring and diligent data collection on the implementation of this legislation.

Recommendation: this section should also specifically reference that it is an offence to hide or change data regarding when/how/where medical assistance in dying was provided, to ensure appropriate research and review can take place. Data on the implementation of medical assistance in dying should also be available to the public to ensure transparency and accountability. The same applies to the later section regarding Regulations.

7. Changes to Corrections and Conditional Release Act:

Given the growing rates of mental illness and self harm within Canada's Correctional facilities, and given the unique vulnerabilities and challenges facing incarcerated persons, and the imbalance of power and lack of freedom that is inherent in those settings, **cases of medically assisted death for inmates should be reviewed with a high degree of scrutiny. Please ask Howard Sapers, Correctional Investigator, for further thoughts on if/how this could be implemented safely within prisons.** It is very possible that an inmate would request this and be granted it easily, because they are considered of little worth to society as a whole. Given the hidden environment in which they live, abuses can be harder to track or prevent.

Recommendation: maintain the need for investigation or review after death, and ensure the cause of death is described as physician assisted, not "natural causes."

To strengthen safeguards within the legislation, please also consider:

8. **Protection of conscience for medical practitioners and pharmacists (similar to the balance provided in the legislation permitting same sex civil unions, which also provides conscience rights to those who do not want to provide the service).**
9. **Protect the rights of those who provide help and counsel to prevent suicide. Do not leave the door open to future punishment for those who might want to dissuade someone from taking their life.**
10. **Strengthen the review process before the patient dies, and after the patient dies. There needs to be more accountability if something goes wrong. "Reasonable but mistaken belief" clause: does this line up with current practices in the medical field regarding malpractice and wrongdoing? There should be just as much accountability here as in other medical situations where something goes awry – if not more so. Practices of assisted suicide and euthanasia should be avoided whenever possible, should be very rare, and only a very last resort.**