Submission to: the Special Joint Committee on Physician-Assisted Dying.

from: Katherine Meaney Svec

Dear members of the Special Joint Committee on Physician-Assisted Dying,

I have a health care background and my experiences over the years, working with patients in a hospital environment, have been instrumental in forming the opinions on Physician-Assisted Dying expressed in this 4-page brief, summarized below.

1. Requests by a competent person for access to assisted-dying at a future date, should they become incompetent, must be complied with, including incompetency due to dementia.

2. Eligibility **(a)** should be determined by competency not chronological age. **(b)**While it is the duty of the physician to assess competency, it is up to the patient to assess the magnitude of suffering.

3. Non-compliant health care providers, hospitals, and care facilities must not impede an eligible patient's right to obtain Physician-Assisted Dying.

4. Physicians need clarity and firm guidelines e.g. How are Ontario physicians to comply with the CMA Policy of no duty to refer which is at odds with the CPSO policy on this issue?

5. Safeguards **(a)** must include strict oversight of, and documentation for each step of the process but overly-complex paperwork must not delay provision of aid. **(b)**Tracking of medication dispensed is essential.

6. Every Canadian deserves end-of-life choice: access to both Palliative Care and Physician-Assisted Dying. There is no reason they cannot co-exist as options.

1. <u>Advance Directives</u>: I have for several years held workshops on the importance of advance care planning, and by far the greatest fear was that of dementia, and the greatest number of questions from participants was how to avoid being kept alive in such a state, when they had clearly stated in writing it is not their wish. My only answer was that as the law now stands, we have no protection against that. It is past time we had such a law.

Therefore, requests made by a competent person for access to assisted dying at a later date should be complied with. If one of the conditions stated is dementia, it is essential to specify under what conditions the request is to take effect. (e.g. *if I cannot feed/toilet myself*…*if I no longer recognize family*…etc.)

2..<u>Eligibility</u>: Criteria for access have been clearly defined in the SCC's ruling in the *Carter* case, and **(a)**eligibility should be determined in the spirit and intent of that ruling. **(b)**Specific medical conditions should not be named: the person best able to assess the severity of suffering is the patient, regardless of its cause. **(c)** In several provinces, Health Care Legislation allows an individual under the age of majority to make their own health care decisions, even when the decision to refuse consent to, or discontinue treatment may lead to their death. There seems no valid reason, therefore, to refuse a competent mature minor access to a Physician-Assisted death.

3..<u>Non-compliance:</u> Many physicians have responded to surveys stating they will not agree to hasten a patient's death, nor will they refer. Other than simply abandoning their patient to self-help, I have as yet seen no alternative offered by these non-compliant physicians. This crucial gap in the process must be addressed and a solution found which balances the rights of such physicians and the rights of suffering patients.

Hospitals and care facilities with a religious component must not be allowed to dictate terms. Patients who meet the criteria and who request Physician-Assisted Dying must have timely access to a cooperating physician.

4. <u>Clear Guidelines:</u> If the CMA insists there is no duty to refer, one is left to wonder how Ontario physicians are to comply, in light of the CPSO's policy on *Professional Obligations and Human Rights* which clearly states:

"Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency.[18] The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients." *(Limiting Health Services for Legitimate Reasons: Policy Number:#2-15 Reviewed and Updated March 2015)*

Of particular note is the fact that this policy was confirmed after the SCC ruling on the *Carter* case, yet there is no mention of any exclusions (such as physician- assisted dying) to be applied to the duty to refer.

5. <u>Safeguards:</u> (a) Two physicians to assess: consult by video should suffice for the 2nd physician. **(b)**Two requests for access, with no waiting period specified, as this is subject to individual prognosis. **(c)**A full review by a licensed body after each death and an annual report with relevant statistics made available to the public. **(d)**Prescriptions filled must be used within a specified period or the medication returned to the pharmacy and a new request for access made. (This is a recommendation made in the proposed Scottish end-of-life Bill in answer to the criticism of the Oregon process where medication dispensed directly to the patient does not appear to be tracked.)

6. <u>End of Life Choice:</u> It is noteworthy that in several jurisdictions where Physician-Assisted Dying has been legalized, access to Palliative Care has increased substantially and this is an attainable goal for which to strive whilst crafting legislation.

I thank the Committee for the opportunity to submit this brief.