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Brief for the Special Joint Committee on Physician-Assisted Dying

About CIJA

As the advocacy agent of the Jewish Federations of Canada, the Centre for Israel and Jewish Affairs (CIJA) is a national, non-partisan, non-profit organization dedicated to improving the quality of Jewish life in Canada by advancing the public policy interests of Canada's organized Jewish community.

CIJA builds and nurtures relationships with leaders in government, media, academia, civil society and other faith and ethnic communities to ensure greater understanding of the issues that impact the Jewish community. CIJA combats antisemitism and discrimination in all its forms and advocates for fundamental rights and freedoms, social justice, and support for the people of Israel.

CIJA connects the power of a strong, national network to regional efforts in every Canadian province and, as the Canadian affiliate of the World Jewish Congress, to international efforts worldwide.

The positions articulated in this document are not a comprehensive formula addressing every aspect of Physician Assisted Dying (PAD). They do not present an articulation of Jewish religious law on this issue, or the orientation of any particular religious stream within our community. This document does not purport to convey the uniform position of all Jewish Canadians, but it faithfully represents what we believe are key points of unity on this highly contentious issue within the organized Jewish community.

Physician Assisted Dying in Canada

There has been vigorous debate within Canada's Jewish community regarding PAD, with a diversity of viewpoints rooted in compassion, religion, ethics and medical practice. The Supreme Court's decision in *Carter v. Canada* to strike down the federal law that prohibits PAD, therefore, met with mixed response.

Many in the Jewish community support the Supreme Court's decision as a moral imperative, empathizing with the rights of the terminally ill to end their lives on their own terms. Many others oppose it for a variety of reasons including traditional religious principles and fear of a slippery slope toward a more broad-based application of euthanasia in Canadian society.

Despite divergent opinions on whether PAD should be permitted in Canada, there is a strong consensus that, following the Supreme Court's determination in this matter, substantial measures are required both to protect those healthcare providers refusing to participate in PAD services for reasons of conscience and to ensure that the

implementation of PAD is sufficiently regulated. Clear, enforceable definitions of what is permitted and what constitutes proper conduct are required to ensure that no one is pressured into ending their life and that freedom of conscience is protected for healthcare providers.

There is also a clear consensus in our community that palliative care should be made universally available as an end of life option in conjunction with PAD services becoming available. PAD is not a substitute for palliative care, home care and support for the terminally ill and their caregivers. It is essential that PAD not be the only alternative available to Canadians as they consider end of life care.

Determining Eligibility

Carter v. Canada determined that, in certain circumstances, a “competent adult” should not be prevented from accessing PAD. However, the Supreme Court did not specifically define how “competent adult” should be interpreted.

We suggest that a patient should be required to demonstrate sufficient mental capability to make an informed decision at the time of any request for PAD, and be capable to consent in line with the requirements in place for other serious medical procedures.

Reflecting the views of many in our community, we empathize with patients below the age of majority who are suffering from a terminal condition and may wish to avail themselves of PAD. However, there are significant concerns both with minors taking such a grave decision on their own and with parents taking such a decision on behalf of their child.

Given the finality of PAD, a cautious approach to criteria for consent is warranted. In our view, only adults who have reached the age of majority in their province or territory should be able to consent to PAD. This is consistent with PAD laws in Quebec and other North American jurisdictions, with the Netherlands and Belgium standing alone as the only jurisdictions to enshrine a right to PAD for minors.

Carter v. Canada limits PAD to patients with “a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.” There is broad based consensus among our constituency that this term should be more explicitly defined in law.

The requirements codified in Quebec’s Bill 52 could be considered a blueprint in this regard. According to Bill 52, all of the following conditions must apply: a patient must “be at the end of life; suffer from a serious and incurable illness; be in an advanced state of irreversible decline in capability; and experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.” This orientation is universal across all North American jurisdictions, which permit PAD only for patients nearing a natural death. The requirement in Oregon is particularly specific in this regard, requiring “an incurable and irreversible disease that

has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”

One suggestion we received as part of our consultation involved restricting PAD to palliative care physicians or facilities as an effective way to ensure that it is provided as one among several options for end of life care, administered by those physicians with the greatest expertise in this stage of life and the options available to patients. However, this was not a uniform position. Others felt strongly that PAD should be kept separate from palliative care, in order to maintain the distinct nature of these end of life choices that some view as antithetical.

The North American approach differs from the framework established in European countries like Belgium and the Netherlands, which do not restrict PAD to the end of life. We empathize with the motivations of those advocating for an approach to PAD modeled on these countries, however concerns have been raised regarding these models producing a slippery slope toward more broadly applied euthanasia, an outcome feared by some in our community. These concerns appear to be beyond the scope of what the Court contemplated in its *Carter v. Canada* decision, which stated that “high-profile cases of assistance in dying in Belgium... would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions.”

Safeguarding Consent

Given the finality of PAD, consent should be subject to clearly defined and monitored safeguards to ensure the decision is fully informed, voluntary and free of coercion. In addition to competency, the patient’s physician should be responsible for ensuring these safeguards for consent are adhered to throughout the process.

Before consent can be determined, a patient should be provided with the following information:

- Their medical diagnosis, prognosis and life expectancy
- The potential risks associated with the medications to be provided
- The course and probable outcome of the procedure
- All alternative options to PAD, including palliative care, pain and symptom control, etc.
- Guaranteed opportunities to seek counsel from anyone they wish (mental health professionals, family, appropriate clergy, another physician, etc.)
- Their right to revoke consent to PAD at any time, by any means

The physician should clearly communicate this information and verify that it has been fully understood by the patient.

A second opinion from a physician independent of both the patient and the primary physician should be required to ensure the eligibility, competency and informed consent requirements have been fulfilled. Independence should require, at a minimum, that the

second physician not be a member of the patient's care team. The second physician should also be qualified to provide diagnosis and prognosis of the patient's condition.

To request PAD, the patient should be required to complete a standard form established by the government for these requests that is designed for clarity and accessibility. If the patient is physically incapable of doing so, they may designate a third person to sign for them, but that person must be a competent adult and cannot be a member of the medical team attending to the patient.

The form should be signed in the presence of a medical or social services professional that countersigns. Both the physician that will administer PAD and the independent physician that will provide a second opinion must see the signed form. Both physicians should be required to ensure that the patient is competent and that their consent is fully informed and voluntary.

Independent psychiatric or psychological assessment of the patient's competency should be provided whenever there is a question of undiagnosed or untreated mental illness impeding competence for voluntary consent.

Voluntary consent should require the following criteria to be fulfilled:

- The decision is made freely, without coercion or undue influence from family members, healthcare providers or others
- The patient has a clear and settled intention to proceed with PAD after due consideration
- The patient has requested PAD him / herself, thoughtfully and repeatedly in a free and informed manner.

The voluntary nature of a patient's request for PAD can be determined through communications exploring the priorities, values and fears of the patient within the context of the physician providing the information listed above. If either physician evaluating the patient determines that the patient's request for PAD is not voluntary, they should reject the request, informing the patient, the other physician and the administration of the medical facility of the reasons for their decision. An appropriate review commission, such as a provincial consent and capacity board, could then reconsider this decision.

A sufficient wait period should be established between the patient's initial request for PAD, the first assessment made by the patient's physician and the second assessment made by an independent physician. This will ensure the patient's voluntary decision and competency are consistent over time. However, the wait period should be reasonable, not a process so prolonged that it functionally prevents patients from accessing PAD. In all cases, the patient should be reminded that they retain the right to revoke their request for PAD at any point in the process.

There is a broad-based consensus within our community that Canadians should be able to provide consent for PAD in advance of physical or mental deterioration through a

living will or other legal instrument, establishing a request for PAD in the event he or she becomes incapacitated. Providing this consent should be subject to the same rigour described above to ensure it is competent, informed and voluntary. It should also be completely revocable by the patient at any point by any means of communication.

Regardless of the specific details of the safeguards put in place by federal and provincial legislatures, the overarching imperative of ensuring a fully informed, voluntary and competent decision to proceed with PAD must be ensured.

Healthcare Providers

PAD should not be provided without medical supervision to ensure the lethal medication is administered properly and safely. The patient's physician or other qualified healthcare provider should remain with the patient until death, prepared to reverse the procedure if possible should the patient decide to revoke their consent.

Any healthcare provider refusing to administer PAD would have a responsibility to inform the patient, to continue caring for the patient and to provide all other treatment options available.

All healthcare providers, including physicians, nurses, pharmacists and others, should be explicitly guaranteed a right to refuse to provide PAD for reasons of conscience in all circumstances. This is entirely consistent with the *Carter v. Canada* decision, which explicitly noted: "nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying." Instead, the Court left it to the appropriate legislative and regulatory bodies to determine specifically how the competing charter rights of patients and physicians should be reconciled.

There are deeply held religious, moral and professional convictions among many healthcare providers that consider referring their patients to another, willing provider an unconscionable breach. We are sensitive to this consideration, which must be balanced with the patient's right to access PAD as established by the Court. One possible accommodation could require the refusing healthcare provider to inform a designated administrator of the medical institution of their objection. That administrator would be responsible for transferring care to another medical practitioner who is willing to provide PAD, in a timely manner, without the refusing provider's involvement.

We acknowledge that this formulation may still not be completely satisfactory for patients or healthcare providers. Regardless of the formula, the rights of a medical practitioner to refuse to participate in PAD for reasons of conscience and the rights of the patient to access PAD under certain circumstances must be respected and balanced to the greatest extent possible.

Accordingly, healthcare providers should be explicitly protected from discriminatory employment practices on the basis of their willingness to provide PAD to patients.

Healthcare Institutions

There is significant debate regarding whether publicly funded healthcare institutions should have the option to decline to provide PAD. This concern has been raised primarily for institutions with a religious affiliation and palliative care or hospice care facilities.

We support the greatest possible protection of freedom of conscience with regard to PAD. However, this must be balanced against the rights of the patient, who may be forced to endure significant hardship to access PAD services elsewhere. Due either to the health condition of the patient or the proximity of an alternate facility, this balance could, in many cases, be very difficult to achieve.

Some have suggested PAD be provided exclusively by physicians specializing in PAD at separate, PAD-specific facilities. This would counteract the possible negative impact on patients of healthcare providers and institutions refusing to provide PAD for reasons of conscience. Others have suggested that publicly funded facilities should have no choice in this matter.

Ultimately, the most important consideration is that the rights of patients to access PAD in certain circumstances and providers to refuse to offer it are balanced to the greatest extent possible. Regardless of the formulation, healthcare institutions that oppose PAD and refuse to provide it should be barred from penalizing or prohibiting medical practitioners from providing these services in other locations.

Review Mechanism

Following the provision of PAD, a physician should be required to report to the healthcare institution's administration, complete a death certificate listing PAD as the cause of death, complete any relevant insurance forms, and report to a government ministry or commission charged with PAD review.

An appropriate government ministry or government mandated commission should review each case of PAD after it has been provided. This review should include consideration of the physician's report and any complaints filed alleging misconduct in the provision of PAD.

Findings of noncompliance with established standards or other malpractice should be reported to the relevant Minister, professional college or police as appropriate. Clear penalties for misconduct should be delineated in advance by professional colleges and in law to deter malpractice and punish offenders, and these penalties should be enforced vigilantly.

Once PAD becomes available to Canadians, it would be beneficial for data to be made available as openly as possible, while still respecting patient confidentiality, to enable stakeholders to evaluate the policies put in place and to continue providing constructive feedback to government on this evolving issue.