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COLLECTIF DES MÉDECINS CONTRE L'EUTHANASIE

BRIEF SUBMITTED TO THE SPECIAL JOINT COMMITTEE ON PHYSICIAN-ASSISTED DYING

Brief submitted by the *Physicians' Alliance against Euthanasia* to the Special Joint Committee on Physician-assisted Dying

Introduction:

The **Collectif des médecins contre l'euthanasie/ Physicians'' Alliance against Euthanasia** was formed in Quebec in 2012 because of the grave concerns felt by many physicians as we saw our province moving toward legalization of euthanasia. The Alliance now has **750 physician members and 14,000 citizen supporters**. We testified before the parliamentary committee prior to the adoption of the Quebec law, and we were an intervener in the *Carter* case before the Supreme Court of Canada.

Our physician members, from all fields of practice, see any law allowing physicians to intentionally end the life of their patients or to help them to do so as contrary to the goals of medicine and the good of our patients, especially the most vulnerable and those who cannot speak for themselves.

The current situation in Canada

The Supreme Court of Canada, in the *Carter* decision, decided that assisted suicide must be permitted in Canada**.** The lifting of the millennial prohibition against certain acts intended to end the life of an innocent person **does not in any way make homicide or assisted suicide a medical act**, which it is plainly not, according to the worldwide professional consensus on this question.[1] The Court judgment **in no way obliges the medical profession or individual doctors to make death available to their patients**: indeed it says explicitly that it does not require doctors to participate in taking patients' lives.[2]

For this reason we note with great consternation several elements of the public debate in the last year. In particular we draw the Committee's attention to the **report of the *Provincial-Territorial "Expert" Advisory Group*,** which, far from being a neutral academic study of the situation, is a radical pro-death manifesto. Its authors, several of whom are well-known euthanasia activists, clearly have no other goal than the unfettered promotion of euthanasia and assisted suicide throughout Canada. They abandon all caution, make no attempt to prevent harm, and demolish all the safeguards that the Supreme Court of Canada included in the *Carter* decision, interpreting them with the undisguised intention of mandating death on demand for everyone.

Quebec's *Act respecting end-of-life care*, in effect since December 10, 2015, has been held up by many as a model to be followed by the Canadian government. It is no such thing. The eligibility criteria, which require that the person *suffer from*

[1] http://www.wma.net/en/30publications/10policies/e13b/
[2] Supreme Court of Canada, Carter v. Canada2015 SCC 5, at para. 131, "...nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."

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[3], are wide open to subjective interpretation and could include huge numbers of Quebecers who suffer from chronic illness, including psychiatric illness, or illness that may become terminal but not in the short term. The requirement that the person be at the end of life is not defined and there is no consensus on what it means.

The *Practice Guide* issued by Quebec's *Collège des médecins* requires that doctors who euthanize patients falsify the death certificate by writing the underlying illness as the cause of death, rather than the act that killed the patient[4]. This is purported to protect patient confidentiality but in fact, above all, protects doctors from prosecution by families who may have reason to believe their relative was euthanized without having requested it or without having met the criteria established in the law.

The Quebec *Act* also requires all public health care institutions, without exception, to provide euthanasia to all patients who meet the established criteria[5]. It requires doctors who refuse to participate to refer patients to the executive director of the institution, who has the obligation of finding a physician willing to kill the patient[6]. Free-standing palliative care centres are exempted from this rule, but we have already witnessed the government's intimidation tactics and threats of funding cuts toward the vast majority of the centres which, to no one's surprise, announced that euthanasia is incompatible with their mission and that they would not carry it out within their walls.

We are afraid for our patients.

Our clinical experience

Consider the experience of Jean-Claude, a patient of Dr. Caroline Girouard, a Montreal oncologist. He is a retired construction worker who has almost never seen a doctor. His wife finally convinces him to go to the emergency because his back pain is keeping him awake at night and he's short of breath on the stairs. He receives the news that he has lung cancer that has spread to his bones. With recent

[3] *An Act respecting end-of-life care*, article 26, paras 4 to 6 (the "Act").
[4] "The physician must enter the disease or morbid condition that warranted medical aid in dying and led to death as the immediate cause of death... The term medical aid in dying should not appear on the certificate of death." Collège des médecins to Québec, *Medical Aid in Dying Practice Guidelines*, November 2015 update.
[5] Article 7.
[6] Article 31.

advances in medicine there are treatments that can give him several good years, but he's in shock and is not able to hear that. He's seen people with cancer, losing all their strength, vomiting, wasting away. "I'd rather die than go through that", he says. Until now it's been against the law to kill patients, so people like Jean-Claude had a chance to try life instead of choosing death. He meets the criteria for "medical aid in dying" under the Quebec Act: he can be legally killed before he adjusts to the news and is able to listen to what his real choices are.

Consider Marguerite, a patient of Dr. Catherine Ferrier in geriatrics. She is a retired schoolteacher with no children, and has no relatives in the city where she lives. Her mind is still sharp but she has painful arthritis and poor vision; her niece hires help for the tasks she finds difficult, so that she can remain in her home. Suddenly, a nephew appears whom she hasn't seen in 30 years. He visits daily, takes her out, and is generally charming. Before we know it she has given him a power of attorney to manage her affairs. "He's the only one who really cares about me", she says. Until one day he disappears and she discovers that her savings have disappeared along with him. She can no longer afford to pay for help and must move to a public nursing home.

This is elder abuse, and it's rampant in Canada. Isolated elderly people, even those whose minds are intact, are a prime target for such predators. After *Carter*, Marguerite's nephew will be able to go one step further to avoid being discovered: convince her, firstly, to change her will to leave everything to him, and secondly, that she is suffering unbearably from her pain and loss of autonomy and would rather be dead. This scenario is very likely and is in no way exaggerated[7]. "Physician-assisted dying" will become the ultimate elder abuse.

Our concerns

Those who promote "physician-assisted dying" presume that everyone is in a position to make a free and rational decision to die. A presumption which would require a world where there are no constraints, no pressures, no fears, no anxiety, no depression, where everyone is honest and altruistic at all times, where communication is faultless and fully understood by everyone, where health care resources are abundant and immediately accessible for all, where those who are sick and aging are constantly surrounded by loving and caring families, where people with disabilities have perfect access to employment, housing and social resources...

[7] http://www.aines.gc.ca/eng/pie/eaa/signs/brochure.shtml#lc3

We do not live in that world. To legalize euthanasia or assisted suicide is to condemn Canadians to choose death because they lack choices or support that would allow them to live.

Ample evidence from jurisdictions that have taken the path of legal euthanasia or assisted suicide documents large numbers of euthanasia deaths without consent[8] and a progressive broadening of the criteria considered acceptable[9], due to a blunting of the collective conscience to the barbarity of the acts being perpetrated.

Euthanasia proponents say that we must make imperfect choices in an imperfect world, and they are right, with regard to other decisions. But there are reasons why we have never taken into our hands to kill people because they are sick. A choice to be killed is of another order, even compared to choices to refuse medical treatment. Canada eliminated the death penalty in 1976, in part because of the risk of error. **Errors will be made, and innocent people, who did not seek death, will die because of the *Carter* decision.**

That is why we believe that the only way to ensure the protection of all Canadians from the effects of *Carter* is to keep euthanasia and assisted suicide a criminal offence. No safeguards can eliminate harm. The risk of unjust, deliberately inflicted death is exceedingly grave, and on a completely different plane compared to the lack of a choice for death, when choices for life can always be offered.

The SCC decision in *Carter* refers repeatedly to the fact that legalizing assisted suicide would entail risks to vulnerable persons, and to the judges' opinion that these risks can be reduced by use of strict safeguards[10]. In requiring the government of Canada to amend the law, **the Court is mandating that strict safeguards be written into the law in order to reduce risk**. While not sharing the Court's trust in safeguards, we do share its desire to see vulnerable Canadians protected.

[8] Chambaere K et al, Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey. CMAJ 182 (9), June 15, 2010. Subsequent discussion between the authors and their critics in the literature did not refute the fact that one-third of the patients in the study died from "physician-assisted death without explicit consent".

[9] See among many references: Lerner BH and Caplan AL, Euthanasia in Belgium and the Netherlands: On a Slippery Slope? JAMA Internal Medicine 175:10, October 2015.

[10] Notably, at paras. 103, 105, 115 and 117 to 119.

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Our proposal

The minimum safeguards we consider necessary, if the government chooses to decriminalize euthanasia or assisted suicide, are as follows:

1. Include in the preamble to the law explicit recognition that assisted suicide and euthanasia are **neither medical acts nor medical care**; that they are **exceptions to the criminal law for very extreme cases**. As such:
    a. They do not fall under provincial jurisdiction over health care;
    b. They require **judicial authorization before the fact** for each case[11] and adequate and transparent reporting procedures;
    c. A person who assists in suicide or who performs euthanasia without respecting the criteria and conditions established in the law is liable to criminal prosecution.

2. **They should never be seen as a "good"** to be promoted and made available to everyone, including those Canadians who are deprived of adequate health care, as is recommended by the *Provincial-Territorial Committee*.[12] Populations with known high suicide rates should be especially protected.

3. **Counselling suicide remains a crime.** Section 241 (a) of the Criminal Code is not mentioned in the SCC judgment. Thus, a sick person must request "physician-assisted dying" him/herself. No health professional or other person may suggest it.

4. **No doctor or other health professional should ever be required to participate in "physician-assisted dying",** even by referring a patient to another professional or an administrative body who will facilitate it. There should be no discrimination against health professionals or trainees in the health professions who are unwilling to collaborate in this act. No jurisdiction in the world requires such collaboration.

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[11] This solution was foreseen in the dissenting opinion of L'Heureux-Dubé J. and McLachlin J. (as she then was) in the SCC Rodriguez decision of 1993: *The safeguards in the existing provisions of the Criminal Code largely meet the concerns about consent. The Code provisions, supplemented, by way of remedy, by a stipulation requiring a court order to permit the assistance of suicide in a particular case only when the judge is satisfied that the consent is freely given, will ensure that only those who truly desire to bring their lives to an end obtain assistance.*

[12] See Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report November 30, 2015, recommendation 23 and others

5. Similarly, **all health care institutions should be free to prohibit the practice of euthanasia within their walls**, in order to create a safe space for patients who are afraid of being euthanized without having requested it.

6. **The *Carter* decision explicitly refers to adults.** The term "adult" is understood by everyone and is defined in law by each province or territory; it did not need to be re-defined by the Court. With good reason *Carter* does not admit "physician-assisted dying" for children.

7. Parliament should **define the term "grievous and irremediable medical condition" to mean a terminal illness with a very short life expectancy** (a few weeks); the diagnosis and prognosis should be confirmed in writing by two doctors who have specific expertise related to the patient's condition.

8. **The Criminal Code should explicitly prohibit "physician-assisted dying" for**:
    a. People living with **disabilities**;
    b. People who have a medical condition as a result of an **accident**;
    c. People with **psychiatric illness** or other **psychological or existential suffering**;
    d. People **incapable of decision-making**, even if they indicated their choice by advance directive while capable. Blind adherence to written advance directives is not a sign of good clinical judgment where there is any possibility the person could have changed her mind.

9. **Require the highest standard of medical, psychiatric and palliative care related to the patient's condition**, with optimal symptom control and suicide prevention strategies, before the assisted suicide can be authorized. Without this, there is no true free and informed consent to death, as the patient either does not know, or has no access to, the alternatives.

10. Assisted suicide or euthanasia **should never be authorized for a person who is in a geographic region or a health care institution where the care outlined in the previous point is not available to all patients**. Require creation of a real and effective national palliative care strategy, in collaboration with the provincial governments, within a specified length of time after adoption of this law.

11. Require in-depth interdisciplinary consultation and counselling with the patient, the family and the health care team, in order to **ensure, to the**

> **best ability of the professionals involved, that the patient is capable of decision-making and is not subject to direct or indirect coercion to request death**.

You are in the unenviable position of being members of the Government that will open the door to homicide in the guise of compassion for the sick in Canada. We urge you to act with the gravity and prudence that is called for by a decision of such consequence.

Physicians' Alliance against Euthanasia
Dr. Catherine Ferrier, president
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