



DisAbled Women's Network of Canada

**Réseau d'action des femmes
handicapées Canada**

Parliamentary Brief

Special Joint Committee on Physician-Assisted Dying Comité mixte spécial sur l'aide médicale à mourir

Presented by
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Leadership, Partnership & Networking

ABOUT THE DISABLED WOMEN'S
NETWORK OF CANADA (DAWN-RAFH
CANADA)

Web: www.dawncanada.net

DisAbled Women's Network (DAWN-RAFH) Canada is a national, feminist, cross-disability organization whose mission is to end the poverty, isolation, discrimination and violence experienced by Canadian women with disabilities and Deaf women. DAWN-RAFH is an organization that works towards the advancement and inclusion of women and girls with disabilities and Deaf women in Canada. Our overarching strategic theme is one of leadership, partnership and networking to engage all levels of government and the wider disability and women's sectors and other stakeholders in addressing our key issues.

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Introduction

Good afternoon, I would like to acknowledge the traditional lands of the Algonquin Peoples where you are gathered and the traditional lands of Treaty 7 of First Nations from where I am speaking with you today. Because we are televised, I also wish to acknowledge all of the First Nations, Inuit and Metis peoples across Canada today. I also wish to thank the staff of the Peter Lougheed Centre who made my appearance possible, but most importantly for saving my life.

DAWN-RAFH Canada has advocated on behalf of the interests of women with disabilities and Deaf women as a party intervener before the Supreme Court of Canada in over a dozen cases. DAWN-RAFH Canada has presented legal argument on both Section 15 of the Charter and Human Rights cases on behalf of persons with disabilities that have brought the perspective and advanced the rights of women with disabilities.

DisAbled Women's Network of Canada's (DAWN-RAFH Canada) mission is to end the poverty, isolation, discrimination and violence experienced by women with disabilities and Deaf women. DAWN-RAFH is an organization that works towards the advancement and inclusion of women and girls with disabilities and Deaf women and girls in Canada.

During Bonnie Brayton's (National Executive Director for DAWN-RAFH Canada) and my first year in DAWN-RAFH Canada, we were alarmed because we were approached by three women who were concerned that Do Not Resuscitate (DNR) orders were inappropriately applied to their family members.

While I have been in hospital since 18 Dec 2015, I have been approached three more times, by women, while in a private room with similar concerns. Yesterday, twice in the span of five minutes.

On 23 Dec 2015, a friend who was visiting me in ICU got a phone call that her uncle for whom she is guardian was being admitted from his nursing home to hospital. She met him there and the doctors told her that she should consider not treating him. They compared him to an “old car.” She insisted he be examined and it was merely a urinary tract infection requiring antibiotics. Yesterday, a friend recounted that her husband had been repeatedly sent home from ER while he had been having a stroke. Upon being admitted to another hospital he was being treated and developed heart failure because they upset his fluid balance. The doctors pressured her husband and her not to treat him. He was terrified and upset. Upon summoning the cardiologist, the fluid balance was corrected and he was well within four days. Five minutes later I received a referral from a woman in the community who learned of a man whose wife has terminal breast cancer. This is his email that he has asked me to read you:

“What happened was my wife Sylvia was rejected for getting help as they deemed she was too heavy for care workers to lift as she cannot use her left leg or arm. She was visited by her nurse in charge and let her know the news. I came home to find her upset and crying as well as scared.”

As part of palliative care, there must be support for family members who are caregivers as you can only imagine the toll on their mental health.

As both a National and Provincial leader in the women's disability movement, with experience in the mental health movement and the disability sector; I have been treated much like the prophetess Cassandra, whose prophecies were true, but never acted upon. As a woman with

multiple disabilities that make me ineligible for most treatment programs, as a survivor of profound childhood abuse, my fear of physician assisted death is visceral. The entire board of DAWN-RAFH Canada shares that fear, as do many of our colleagues across the disability sector.

I will begin with our recommendations.

Recommendations

Eligibility Criteria

(e.g. age, capacity, condition, addressing vulnerability)

1. A national, comprehensive, regulatory system is required to protect persons who are vulnerable to being induced to commit suicide in times of weakness, this is especially true for women who are particularly vulnerable.
2. Women with disabilities need to have had a consultation with a peer support group before being eligible for physician-assisted death.
3. Women are made vulnerable as a result of social or economic circumstances that diminish their resiliency. Conditions such as poverty, isolation, discrimination, devaluation and lack of needed supports are therefore highly relevant in determining whether a person may be vulnerable to inducement. (Frazee, Catherine)
4. Women with disabilities are at greater risk of vulnerability because of the emphasis on compliance with caregivers and similar authority figures. This is especially true of women with intellectual disabilities, women with a lived experience of mental illness and survivors of trauma. (DAWN-RAFH)
5. Women and girls with disabilities are especially at risk because they are subject to greater vulnerability to violence and coercion, they also may worry more about being a burden to others. (Masuda, 1995) (Katrina Hedberg, 2001) (DAWN-RAFH)

6. Women with disabilities and their representative organizations have much at stake in the design, delivery and evaluation of any system developed to protect persons who are vulnerable from being induced to request physician-assisted death suicide.
7. Physician assisted death must be available only to competent adults with a grievous and irremediable condition that is the cause of enduring suffering which is intolerable to the individual and only in a province that has high quality palliative care consistently and freely available to those who reside in that province (CWDO).
8. In and of itself, disability is not a grievous and irremediable condition. (CACL)
9. Requests for physician-assisted death must be reviewed and authorized by an independent review panel with sufficient information to determine if the necessary criteria are met. (CWDO)
10. Women with disabilities are horrified that physician-assisted death would be an option for anyone under 18 years of age. This is especially disconcerting in the light of Tracy Latimer's murder.

Processes and Procedures

(e.g. mechanics of a request, oversight, privacy considerations)

1. The Government of Canada must use the Notwithstanding Clause to stop the physician assisted death from moving forward, as it is moving too quickly and procedures and safeguards are insufficient as are alternative resources to physician assisted death. No aspect of Canadian society has had an opportunity to really think about what it is doing. Canada needs to rethink this direction.
2. Canada must ratify the Optional Protocol of the Convention on the Rights of Persons with Disabilities (CRPD).
3. The Convention on the Rights of Persons with Disabilities (CRPD) must be upheld, particularly Articles 4, 6, 10, 19, 25, 26, 28, 32 and 33. Any measures of physician assisted death must be mindful of complying with these articles.

4. All women's services both government and civil society must be enhanced before even one dollar is allotted to physician-assisted death.
5. Before funding for physician-assisted death is provided, programs and services for basic social determinants of health must be made available for women and girls with disabilities (safe barrier free public and medical transportation; affordable barrier free housing; shelters and transitional housing; inclusive employment and education; trauma informed counselling; counsellors who are trained to work with people who have addiction, brain injury, intellectual and other disabilities; food; basic income; homecare; palliative care; mobility devices and other disability related supports)
6. A definition of the terms physician-assisted death, euthanasia, physician-assisted suicide should be included in the legislation. (CWDO)
7. The humanization of medicine and better training for caregivers and health care providers, especially with respect to disability studies. (COPHAN)

Roles and Regulation of Healthcare Practitioners

(e.g. who should do what, rights of conscience, discipline and penalties)

1. In making its decision the review panel must consider the following information:
 - a. The person's request and reasons for the request;
 - b. A clinical evaluation by a two qualified physicians regarding whether the person meets the medical criteria; (DAWN-RAFH)
 - c. A clinical evaluation by a two qualified physicians regarding whether the person's condition is irremediable in the sense that it is likely to cause death within the foreseeable future – one month. Where this prognosis is not the case, special inquiry

must be made into whether there are conditions that place the person at risk of being vulnerable to being induced to commit suicide, and whether all alternative courses of action have been considered. (DAWN-RAFH)

- d. A clinical evaluation by a two qualified physicians or capacity assessors that the person is competent to make the decision; (DAWN-RAFH)
- e. An assessment and documentation by two examiners stating of whether or not the person's request is informed and voluntary; (DAWN-RAFH)
- f. An assessment of potential alternative courses of action that might reduce the person's suffering. This assessment must be conducted by a qualified professional in consultation with the patient, and must address a full range of alternatives to physician-assisted death suicide (CWDO) including medical treatment, palliative care, counselling and disability related supports. Assisted suicide can only be made available after a detailed and individualized plan for high quality palliative care has been thoroughly presented, considered and refused (CWDO);
- g. Accommodations must be made for linguistic barriers for Deaf and hard of hearing people, Deaf/Blind people, Blind people, people with low vision and people with speech difficulties; (DAWN-RAFH)
- h. A full explanation of the risks and complications of physician assisted death must be relayed as a part of informed consent (regurgitation of the medication, length of time to unconsciousness, length of time to death, failure of the procedure). (Amy D. Sullivan, 2000) (Oregon Health Authority, 2015) (DAWN-RAFH)
- i. There needs to be a mechanism of intervention from interested parties who are concerned about the possibility of coercion or discrimination. (DAWN-RAFH)

- j. Submissions by third parties with direct knowledge relevant to the request, subject to the discretion of the review panel.
(DAWN-RAFH)
- 2. Clinical input to the review panel process must come from at least two different physicians. (CAACL)
- 3. A monitoring system and annual public reports to Parliament and provincial/territorial legislatures must be in place to track and report on:
 - a. the number of requests;
 - b. the reasons given;
 - c. using aggregate data (CWDO) medical condition, socio-economic circumstances and demographic factors associated with persons making requests, and those whose requests are authorized or denied;
 - d. availability and acceptance or refusal of alternative courses of action identified;
 - e. efficacy of alternative interventions including access to medical treatment and palliative care;
 - f. aggregate data by gender; (DAWN-RAFH)
 - g. create a mechanism for families and other interested parties to call for an investigation (DAWN-RAFH)
- 4. Measures to be taken in the event of improper use of physician assisted death. (DAWN-RAFH)
 - a. Compensation to the estate and/or family members of those who were found to be wrongly given physician assisted death; (DAWN-RAFH)
 - b. There needs to be a mechanism of intervention from interested parties who are concerned about the possibility of coercion or discrimination. (DAWN-RAFH)

Reflection

On 11 March 2010, Canada ratified the Convention on the Rights of Persons with Disabilities. Everyone was very excited and for the first time we had hope that things would become better for our people, particularly with Article 6 emphasizing the particular disadvantage faced by women and girls with disabilities. You can imagine our shock when Canada did not ratify the Optional Protocol. That was just the beginning. Canada then made profound cuts to every aspect of both government and non-government women serving organizations and agencies. Then, without building up resources to alleviate the violence, economic disparity, crushing poverty, unequal opportunities for education, lack of disability transportation, home care, palliative care, housing, disability and mental health care, our Supreme Court of Canada, in the name of Human Rights, offers us the opportunity to die, at the hands of the very physicians we're supposed to be able to trust to help us.

We do not have Capital Punishment in this country, nor do we extradite offenders to countries who do, because we are concerned that we may inadvertently execute an innocent person and cannot devise adequate safeguards to prevent this. Yet, I find it alarming that in the name of individual rights, our Supreme Court believes that we can. The Carter v. Canada decision is a rush to judgement, compelling governments and Canadian society as a whole, to make rapid decisions on matters Canadians have not had proper time to fully understand or consider.

Processes and Procedures

Let us synthesize these broad themes by reflecting on the case of Ms. Misty Franklin. She grew up in a violent, unsupported home and at age 24, met Trevor Fontaine who had an extensive criminal history for sexual assault and violence against women. Within four months of meeting him, she was stabbed in the neck with a pair of scissors, rendering her in a coma and became a quadriplegic as the result of her injuries. She had initially requested to be disconnected from her ventilator on 30 October 2013, but as the date drew near she felt she still wanted to do a few more things and have a bit more time. Ten years after her injury, on 28 Jan 2014, she died when she was withdrawn from her ventilator by her own request.

Misty didn't have intervention as she was growing up in a situation of family violence. She didn't receive the upbringing and life skills that would prepare her for a family of her own or the education to prepare her for a career. Misty's marriage broke down and she was a single mother living in a shelter with two small children, falling into the party scene and experimenting with drugs. She did not have any internal resources or family supports to re-establish herself even before her injuries. The Appendix A has a fulsome discussion and history which illustrates more fully how this lack of support deepened as her disability progressed. The loss of women's services make disabled women especially vulnerable to the risk of physician assisted death.

Let's connect the issues raised in my earlier remarks. We see everything experienced by Misty is like checking off a tick box of all of the missing resources first that Misty would have needed to prevent the injuries that led up to her becoming disabled in the first place, and then the missing resources that would have allowed our sister with a disability to lead a safe and effective life.

It is unacceptable that one dollar should go to physician assisted death before the necessary resources are in place to ensure that women with disabilities are not condemned to death.

Roles and Regulation of Healthcare Practitioners

Women with disabilities often do not have a primary care physician. The problem with the policies and “safeguards” is that it is assumed in the physician assisted dying documents, that every Canadian has a primary care physician, when this is not the case. In actual fact, when you end up in intensive care or an emergency room, you are being cared for by strangers. Your entire hospital stay, you will not be seen by your family doctor and you will not be seen by the same doctor as they rotate routinely.

APPENDIX A

Abridged from the **Last Goodbye Three Part Series of the Edmonton Journal from 2013 Dec 09, 2014 Jan 08 and 2014 Jan 27.**

Misty had grown up in Chetwynd, B.C., west of Grande Prairie, an independent, strong-willed girl with a “wild streak”. She loved poetry and art, but her happiest moments were riding her horse through the foothills of the Rockies. Her family life was turbulent. Things could get violent between her parents, the mood in the house sometimes changing so quickly it felt to Misty like someone had flipped a switch. She left home as a teenager, looking to make her own way in the world.

Misty was struggling. Her marriage had fallen apart, she was partying too much and had got into drugs. Her daughters, Shianne and Brooklynn, were six and three. They’d gone to live with family while she tried to get herself settled, and she missed them badly. She wanted to get into rehab, then maybe get a job as a legal secretary.

She met Trevor Fontaine in Prince George, B.C., in September 2003, through her cousin. Trevor was charismatic and outgoing, having an instinct for finding people he could use and manipulate.

Trevor was living at the Ketso Yoh, a federal halfway house in downtown Prince George, where he was on parole after serving four years of a five-year sentence for sexual assault and attempted murder. The halfway house was across the street from the Quebec Street Women’s Shelter, where Misty was staying.

Trevor grew up in Manitoba, a ward of the government on and off from the age of four. Prison documents describe a childhood of neglect, violence, and allegations of sexual abuse by his mother and another relative.

Though he faced a steady stream of charges for robberies and other violent crimes from the time he was a teenager, Trevor's most serious violence was reserved for women he was dating. He often raped and choked his girlfriends, sometimes holding knives to their throats. He burned one of his girlfriends with cigarettes and lighter fluid. He bit another woman on the face. One woman he was dating nearly died after he choked her, beat her with a frying pan, and then stabbed her in the back, leaving her bleeding on the kitchen floor of a rundown house in Winnipeg.

He choked another woman so hard during a sexual assault that he crushed her voice box, leaving her permanently unable to speak above a low whisper. For years afterward, the woman still wore pants to bed and she woke up most mornings at 4:50 a.m., the time he attacked her. He was on parole for the sexual assault and attempted murder of that woman when he met Misty in the fall of 2003.

When another resident of the halfway house reported seeing Trevor grab Misty on the street, a parole officer met with the couple and told them the relationship had to end.

Misty and Trevor agreed to stop seeing each other, but staff at the halfway house suspected he was sneaking out to see her, telling them he was going jogging or to the mall. When he went out for cigarettes and was gone two hours, a parole officer moved to revoke his parole. Trevor was looking out the window of the halfway house when he saw RCMP officers coming to arrest him, and he fled out the back door and went on the run.

Three days later, on Dec. 18, 2003, Trevor and Misty were together at her cousin's house near Vanderhoof. They started to argue. He picked up a pair of scissors, and stabbed them into the back of her neck.

Misty lay on the floor for a long time before Trevor finally let her cousin call an ambulance. He kept her cousin and her three children trapped inside a bedroom until he came up with a story he could tell the police. He warned the kids not to crawl out the window, telling them: "I don't want to kill anybody else."

When the paramedics finally arrived, Misty was unconscious and nearly dead. An RCMP officer contacted Misty's family and told them she had been stabbed. They raced to the hospital in Prince George over bad roads from northern B.C., not knowing whether she would still be alive when they got there.

She lay in a coma for days, coming into consciousness slowly. Misty's spinal cord had been severed by the stab wound. She was now a quadriplegic, unable to move below the shoulders.

She was on a ventilator and couldn't breathe on her own, and doctors told her family she probably wouldn't ever be able to eat or talk again.

Misty did better than the doctors had predicted. Two years after she was hurt [2005], she could eat and talk. She could be off her ventilator most of the time, and she was able to live in Grande Prairie with family. She learned to paint with her mouth, and found moments of escape in the colourful lines that appeared from her brush.

In June 2006, a jury found Trevor guilty of 10 charges for the attack on Misty, including aggravated assault, assault with a weapon and unlawful confinement for preventing her cousin and her cousin's children from leaving the house.

Trevor was declared a dangerous offender in the summer of 2008 and sentenced to an indefinite term in prison. He came up for parole in 2011 and again in March 2013 but the parole board denied his release both times, saying in a written decision that he'd been assessed as being "in the early stages" of managing his anger and dealing with his emotional issues.

On a trip to Edmonton to be fitted for a new wheelchair a few years ago, Misty had an allergic reaction to some pain medication and went into anaphylactic shock. She fell into a coma, and again nearly died. When she woke up, she was back on the ventilator full time. It meant she needed to stay in Edmonton, away from her family and friends, and far from her daughters.

In the years after she was hurt, the feeling in Misty's body had turned from numbness to agonizing pain. Though she couldn't move below the shoulders, she could still feel her body, and the pain of muscle spasms, contractions, and cramps left her delirious and screaming.

She had grown big from steroids and lack of movement, as it was often too painful even to have range of motion exercises done on her arms and legs. She could be difficult or rude with people who worked with her, and had a reputation with some at the care home and at the hospital as a troublemaker.

Misty thought about committing suicide many times, and had, at the most difficult moments, even begged members of her family and doctors to kill her. But she never did it, mostly because of her daughters. After Misty was hurt, Brooklynn and Shianne lived with Brooklynn's paternal family in B.C., seeing their mother infrequently, with months, and sometimes longer, passing between visits.

It was in 2013, around her daughter's 16th birthday that Misty started to think seriously about coming off her ventilator. She was entering her tenth year as a quadriplegic, and, in many ways, things were worse than they had ever been. She spent most days in a haze of pain and medication, sleeping or looking out the window, watching images pass on her big-screen TV, feeling the ventilator pushing air into her body. Some days, she barely woke up at all. She preferred to sit up in her wheelchair, but if she was too sore or sick or had bedsores, she had to stay in bed.

The relationship between Misty and her parents had been strained and distant for a long time, and by 2013, she had barely seen either of them for years. Misty was still resentful of the turmoil in her home growing up. Ken Franklin told his daughter that things would be better if she was on less medication and could get back up to Grande Prairie and live closer to family. He doubted whether the pain was as bad as she said it was, and he thought she was simply giving up.

She picked Oct. 30, 2013, as the day she wanted to die. Being removed from a ventilator is a legal right in Canada, having been won in the 1992 court case of Nancy B., a 25-year-old Quebec woman who was paralyzed and on a ventilator because of Guillain-Barré syndrome.

Dalhousie University professor Jocelyn Downie, an expert on end-of-life issues in Canada, said people can choose to be removed from a ventilator as long as they are older than 18, have the mental capacity to make a free and informed decision, and understand what will happen once the ventilation is removed.

Downie cited one study that showed about 90 per cent of critically ill patients in Canada die after the removal of some form of life-support. "People are withdrawn from ventilators all the time," she said. "Maybe people don't realize how much it happens, but it's common."

In the middle of October, Misty realized that the day she expected to die was just weeks away.

She'd long been adamant that she was ready to die, but suddenly it felt like time was going by too quickly. There were still things she wanted to do. She wanted to go to the rodeo, and maybe take her daughters to Jasper. She felt like she needed more time. Saying goodbye was harder than she thought, and she was scared.

Early in the new year, another date was set: Tuesday, Jan. 28. This time, Misty did not change her mind.

She asked people "Just think of me, not in this room, but somewhere, running with my horses," she said.

APPENDIX B

What really would have saved Misty Franklin - recommendations:

- The Government of Canada must use the Notwithstanding Clause to stop the physician assisted death from moving forward, as it is moving too quickly and procedures and safeguards are insufficient as are alternative resources to physician assisted death. No aspect of Canadian society has had an opportunity to really think about what it is doing. Canada needs to rethink this direction.
- Canada must ratify the Optional Protocol of the Convention on the Rights of Persons with Disabilities (CRPD).
- The Convention on the Rights of Persons with Disabilities (CRPD) must be upheld, particularly Articles 4, 6, 10, 19, 25, 26, 28, 32 and 33. Any measures of physician assisted death must be mindful of complying with these articles.
- The restoration of funding to women serving agencies, both government and civil society.
- Proper resources to prevent and protect women and girls from violence and abuse.
- Accessible and inclusive women's shelters, transitional and permanent housing opportunities for disabled women and girls.
- Ensure equal inclusive opportunities for education and employment.
- Ensure proper income support for women and girls who are unable to participate in education and employment so they are not vulnerable to abuse and exploitation.
- Ensure safe and reliable transportation for women and girls, by all modes of public and medical transportation.
- Homecare and palliative care must be made part of our health care and be equivalent across our country rather than trapping people in a geographic area. It needs a national standard.

- Mental health care **MUST** be accessible to every citizen in our Country before one dollar is spent making one "review panel" for physician assisted death. We do not have enough dollars to save the thousands of people who die each year from suicide to spend one cent on the industry that seeks to kill our own people. Mental health care must have professionals who are cross-trained in trauma, addiction and disability.
- Women with disabilities need access to legal assistance for personal directives, wills, supportive decision making agreements, divorce, and many other protections for their rights such as landlord tenant that could also help protect them.

APPENDIX C

Physician-Assisted Death in Canada:

Fundamental Principles

- A national, comprehensive, regulatory system is required to protect persons who are vulnerable to being induced to commit suicide in times of weakness.

- People are made vulnerable as a result of social or economic circumstances that diminish their resiliency. Conditions such as poverty, isolation, discrimination, devaluation and lack of needed supports are therefore highly relevant in determining whether a person may be vulnerable to inducement. (Frazee, Catherine)

- People with disabilities are at greater risk of vulnerability because of the emphasis on compliance with caregivers and similar authority figures. This is especially true of people with intellectual disabilities, people with a lived experience of mental illness and survivors of trauma. (DAWN-RAFH)

- Women and girls with disabilities are especially at risk because they are subject to greater vulnerability to violence and coercion, they also may worry more about being a burden to others. (Masuda, 1995) (Katrina Hedberg, 2001) (DAWN-RAFH)

- Persons with disabilities and their representative organizations have much at stake in the design, delivery and evaluation of any system developed to protect persons who are vulnerable from being induced to request physician-assisted death suicide.

- The Convention on the Rights of Persons with Disabilities must be upheld, particularly Articles 4, 6, 10, 19, 25, 26, 28, 32, 33. (DAWN-RAFH)

Guidelines for Legislative and Policy Response

1. The legislation should only be about physician-assisted suicide. (CWDO)
2. A definition of the terms physician-assisted death, euthanasia, physician-assisted suicide should be included in the legislation. (CWDO)
3. Assisted suicide must be available only to competent adults with a grievous and irremediable condition that is the cause of enduring suffering that is intolerable to the individual and only in a province that has high quality palliative care consistently and freely available to those who reside in that province (CWDO).
4. In and of itself, disability is not a grievous and irremediable condition. (CAACL)
5. Requests for physician-assisted death suicide (CWDO) must be reviewed and authorized by an independent review panel with sufficient information to determine if the necessary criteria are met.
6. In making its decision the review panel must consider the following information:
 - a. The person's request and reasons for the request;
 - b. A clinical evaluation by a two qualified physicians regarding whether the person meets the medical criteria; **(DAWN-RAFH)**
 - c. A clinical evaluation by a two qualified physicians regarding whether the person's condition is irremediable in the sense that it is likely to cause death within the foreseeable future – one month. Where this prognosis is not the case, special inquiry must be made into whether there are conditions that place the person at risk of being vulnerable to being induced to commit suicide, and whether all alternative courses of action have been considered. **(DAWN-RAFH)**

- d. A clinical evaluation by a two qualified physicians or capacity assessors that the person is competent to make the decision; **(DAWN-RAFH)**
 - e. An assessment and documentation by two examiners stating of whether or not the person's request is informed and voluntary; **(DAWN-RAFH)**
 - f. An assessment of potential alternative courses of action that might reduce the person's suffering. This assessment must be conducted by a qualified professional in consultation with the patient, and must address a full range of alternatives to physician-assisted death suicide (CWDO) including medical treatment, palliative care, counselling and disability related supports. Assisted suicide can only be made available after a detailed and individualized plan for high quality palliative care has been thoroughly presented, considered and refused (CWDO);
 - g. Accommodations must be made for linguistic barriers for Deaf and hard of hearing people, Deaf/Blind people, Blind people, people with low vision and people with speech difficulties; **(DAWN-RAFH)**
 - h. A full explanation of the risks and complications of physician assisted death must be relayed as a part of informed consent (regurgitation of the medication, length of time to unconsciousness, length of time to death, failure of the procedure). (Amy D. Sullivan, 2000) (Oregon Health Authority, 2015) **(DAWN-RAFH)**
 - i. There needs to be a mechanism of intervention from interested parties who are concerned about the possibility of coercion or discrimination. **(DAWN-RAFH)**
 - j. Submissions by third parties with direct knowledge relevant to the request, subject to the discretion of the review panel. **(DAWN-RAFH)**
7. Clinical input to the review panel process must come from at least two different physicians. (CACL)

8. A monitoring system and annual public reports to Parliament and provincial/territorial legislatures must be in place to track and report on:
 - a. the number of requests;
 - b. the reasons given;
 - c. using aggregate data (CWDO) medical condition, socio-economic circumstances and demographic factors associated with persons making requests, and those whose requests are authorized or denied;
 - d. availability and acceptance or refusal of alternative courses of action identified;
 - e. efficacy of alternative interventions including access to medical treatment and palliative care;
 - f. aggregate data by gender; **(DAWN-RAFH)**
 - g. create a mechanism for families and other interested parties to call for an investigation (DDD) **(DAWN-RAFH)**
9. Measures to be taken in the event of improper use of physician assisted death. **(DAWN-RAFH)**
 - a. Compensation to the estate and/or family members of those who were found to be wrongly given physician assisted death; **(DAWN-RAFH)**
 - b. There needs to be a mechanism of intervention from interested parties who are concerned about the possibility of coercion or discrimination. **(DAWN-RAFH)**
- 10. The humanization of medicine and better training for caregivers and health care providers. (COPHAN)

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"Women with disabilities often feel like burdens to the family, and many are abused and neglected. These are the women who are most susceptible to suicide and suicide from covert or blatant persuasion. Seventy-eight (21.7%) of Women in this survey had been told that they would be better off dead, and an additional 94 (26.2%) had been told that it would have been better if they had never been born. Fifty-nine (16%) women had experienced both sentiments. An important follow-up survey of women with disabilities in the next five successive years would ask these same questions about whether women feel valued in a society that is encouraging the killing of the "unfit" for its own reasons and not ours."

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