

Submitted by:

Dr. Carolyn Inch

I am writing as a citizen expressing my personal views. I am a member of Dying With Dignity. Issues that they have identified and that I support are included in the letter below.

February 6, 2016

Dear Special Joint Committee on Physician-Assisted Dying,

Executive Summary:

I would like to ensure that, as a Canadian, I am given the option of controlling my end of life choices. In my opinion, the most important powers in the future legislation should ensure that:

- 1. Advance requests for assisted death are valid when made by a patient who, at the time of the request, was competent and had a diagnosis for a condition that was or could become grievous and irremediable.*
- 2. "Grievous" is defined as a very severe or serious illness, disease or disability; a list of approved qualifying conditions must not be compiled.*
- 3. The site of physician assisted dying need not be restricted to institutions depending on the agreement of all parties.*

To expand:

My mother had Alzheimer Disease and died after several years of care in a semi-vegetative state, not recognizing or communicating with anyone. She had been a proud woman who repeatedly said to the family, and more pointedly to her son-in-law who had a farm and was a hunter, "If I get that Oldtimers disease, take me out to the back forty and shoot me, Rick". We all felt that we had let her down every time we looked at the remnants of the person she was in the bed. Hence, the first recommendation is critical, in my opinion. It is framed using the words suggested by Dying with Dignity in order to be clear but my story is meant to provide you with the context with which I am all too familiar.

My background as a veterinarian provides me with a perspective on humane euthanasia. While the participation of qualified individuals is critical, the selection of location and participants should also be a matter of choice for individuals at the end of their lives. In my experience, when owners, representatives of their pets, have been able to choose the time, location and participants for the euthanasia, it has led to the event being less stressful.

So to reiterate these points in a little greater detail and add others of lesser importance to me as an individual at this point in my life but may be important to me in another context:

- 1. Advance requests for assisted death are valid when made by a patient who, at the time of the request, was competent and had a diagnosis for a condition that was or could become grievous and irremediable.*

As illustrated by my story about my mother, this is a critical issue. Parliament must act to ensure that patients whose requests for PAD have been approved — but who then become

incapacitated as the result of a stroke or a coma or dementia for example — are still allowed to have their wishes carried out.

The alternative is the one my family lived or the patient requesting that they be assisted to die while they are still enjoying mental capacity but are preoccupied by their future state being prolonged after they lose their abilities. That wastes precious time at the end of a life.

2. "Grievous" is defined as a very severe or serious illness, disease or disability; a list of approved qualifying conditions must not be compiled.

As I am told in the Dying with Dignity guidelines, in its decision in *Carter v. Canada*, the Supreme Court decriminalized physician assisted dying for competent adult patients who have a "grievous and irremediable" medical condition that is intolerable to them. Because "grievous" is a judicial term and not a medical one, many stakeholders have asked for Parliament to clarify how the word should be interpreted in a healthcare context.

I believe that a list of approved qualifying conditions would unfairly impede access for some patients who are experiencing grievous and irremediable suffering. Thus, eligibility should not be limited to a list of approved conditions and should instead be open to patients with a "very severe or serious illness." That severe illness should be expanded to include not just physical states but mental states that rob the patient of quality of life

Provisions to Protect Patients

3. Two physicians must verify free and informed consent.

DWDC recommends that two physicians assess a patient and verify that the requesting patient has made a free and informed decision. Outside consultations are unnecessary unless the patient's competency is in question.

4. Every case is reviewed after the patient has died. Aggregate data is compiled and made available to the public.

To ensure adequate tracking, each case of PAD must be recorded for research and statistical purposes.

Provisions to Ensure Reasonable Access

5. Other licensed healthcare practitioners may also provide assisted dying to ensure access, especially in remote regions.

Other healthcare practitioners, such as nurses and physicians' assistants, must be granted permission to participate in assisted dying under the supervision and guidance of a doctor. In many remote communities, there is a severe shortage of physicians. For that reason, other registered healthcare professionals should be allowed to assist in the provision of PAD. This measure would help ensure that eligible patients are not abandoned or denied their constitutional right to a peaceful death.

6. Doctors have the right of conscientious objection but must provide information and effective another doctor or a third-party referral agency. Sick and dying patients should not be responsible for finding an alternate doctor on their own.

7. Publicly funded healthcare institutions, including hospitals, hospices and long-term care facilities, are required to provide physician-assisted dying on their premises. Further to this, I would like to see the legislation remain silent on the need for an institutional setting for physician-assisted dying. When all parties are comfortable with an alternative site, the legislation should allow for that.

All publicly funded healthcare institutions must allow PAD on their premises. If no doctors on staff are willing to provide, an external doctor must be permitted into the hospital to provide the service. This policy is especially relevant for small communities where healthcare options may be limited.

I recognize that opening up the sites is a radical proposal but it has been used successfully, if illegally, for several generations. I am aware of at least two cases in which terminally ill patients have been administered lethal doses of barbiturates by their family in their homes at their wish.

In Conclusion

It is my objective to see legislation in Canada that allows me to choose when, where and with whom I die. As well, it is important that I be able to outline what I consider to be the appropriate physical and mental state for my demise in advance of reaching that state.

Thank you for your consideration of my concerns.

Sincerely

Carolyn Inch