The Jt. Committee on Physician Assisted Death
c/o the Clerk of the Committee
House of Parliament
Ottawa, Ontario

Feb. 9, 2016

Dear Members,

I write as a concerned citizen in support, encouragement and appreciation of your work on the Joint Committee on matters of life and death significance to all Canadians.

In an effort to walk alongside the Committee and serve as a sounding board, I have been watching the broadcasts of your sessions, trying to appreciate and evaluate the deeply held and frequently divergent views being presented.

I offer the following comments based on the hearings held to date.

How much has already been decided by the Supreme Court Carter decision?

The decision itself requires legislators to decide the broad range of public policy issues it raises. The Supreme Court's judgment is not self-enacting. The regulatory regime the Court counted upon to justify exceptions to the deliberate ending of another's life is not contained in the decision. The confidence of the public, the integrity of the practice of medicine in Canada, and protection against the infliction of irreversible harm all require the federal Parliament to enact the regime it judges best serves these goals.

Terminology and the Criminal Code

While the term Physician Assisted Dying (PAD) has been widely used in the Committee's discussions, what the Carter case envisions is a specific *act and event not a process*: namely, a physician enabled death. An act that directly and deliberately causes the death of another person is not a treatment for an underlying medical condition. This is why the Criminal Code is engaged. This is also why the conditions that exempt such an act from criminality must necessarily be stringent and included within the Criminal Code itself.

The decision changes the legal framework that has governed end of life practices. The consultation and consent process as it exists now presupposed the prohibition against PAD. The Carter decision now empowers doctors to deliberately kill their patients. This unprecedented mandate requires new legislative standards to protect against abuse.

The prevention of murder is an overarching public policy goal consistent with the Charter. The Criminal Code is more than a set of rules: it embodies and articulates fundamental values and structures the moral framework of our free and democratic society. Parliament will therefore be acting within its jurisdiction in re-articulating these overarching values when responding to the decision.

The Framework: Co-operative Federalism Affirmed

Given our unique constitutional division of powers, to achieve the widely held objectives of pan-Canadian comprehensiveness, clarity and consistency and the protection of the vulnerable, the Framework needs to be an original "made in Canada" template.

While this seems to add yet another layer of complexity and potential political stalemate, the Committee has heard constructive and innovative ways of respecting co-operative federalism in the implementation of PAD.

Professor Peter Hogg's presentation highlighted how the Carter decision expressly tasks the federal Parliament with devising a regulatory regime that will avoid error and abuse in cases of physician assisted death. Protection of the vulnerable through such a regime, in the Court's view, is what warranted its making an exception to the absolute prohibition against assisted suicide and euthanasia in the Criminal Code. The establishment of such safeguards has been widely recognized by your presenters as a valid exercise of Parliament's criminal law jurisdiction.

Accordingly, to discharge its responsibilities under the Carter decision the federal Parliament must provide a self-sufficient act a) to provide the lasting safeguards called for the Court; b) guard against a patchwork of provincial standards, and c) fill any legislative and regulatory void that would exist in the event of a province's taking no action at all.

Mr David Baker has provided you with a preliminary template for such stand-alone federal act. It was also noted that Quebec's End of Life legislation, suitably adapted, could serve as a starting point for comprehensive federal legislation under its criminal law power.

Avoiding a provincial patchwork does *not* mean imposing absolute uniformity. As Professor Hogg noted, and Benoit Pelletier concurred, co-operative federalism enables provinces autonomy to enact their own substantially equivalent regimes, which would, on that basis of equivalency, be declared exempt from the federal regime. Jocelyn Downie likewise acknowledged the potential for provincial inaction and thus the need for clear, comprehensive federal legislation to uphold the rights articulated in Carter. She noted past use of substantial similarity accommodations as a proven method of dealing with jurisdictional and administrative overlap.

Clear, consistent and comprehensive Canada-wide safeguards for the vulnerable are key to gaining Canadians' confidence as we enter uncharted territory. Taking a co-operative federalism approach will enable Parliament to offer the protection Canadians and the Carter decision have called for.

Vulnerability Assessment

The Court mandates the protection of the vulnerable. It is up to Parliament to determine the circumstances that constitute vulnerability.

The Committee has heard ample testimony about the many non-medical factors which result in vulnerability. Establishing eligibility criteria for PAD requires a global vulnerability assessment by a team whose expertise ranges beyond the strictly medical dimension of the person.

The Court contemplates a free, non-coerced, autonomous decision by the sufferer as the fundamental starting point. For this very reason the regulatory regime must ensure factors compromising autonomy and freedom of choice be explored and exposed in advance.

Factoring in the family dynamic is required in the interest of ensuring a free and uncoerced choice. Restricting the circle of consultation to the individual and the physician will not capture these dynamics, thus leaving a patient vulnerable to pressured decisions.

Palliative Care and Consent

Access to palliative care is another contributor to ensuring free and autonomous choice. That is why the palliative care initiatives pleaded for by so many before the Committee come directly within the purview of the Carter criteria and thus need to be included in your framework recommendations.

No choice can be free and autonomous if there is no access to pain relief and palliative care. Palliative care as currently understood and practiced is in fact all about genuine physician assistance in dying – it is a genuine process of accompaniment at the end of life and not a deliberate act ending life.

The Societal Status of Suicide

There is a widespread consensus in Canadian society reflected in current treatment protocols, that the desire to die driven by existential despair, anxiety, and fear about the future is a remediable condition calling for positive interventions not termination.

The many mental health initiatives, and mandated psychiatric interventions where suicidality is evident that are all current public policy objectives would be undermined by enshrining a state-enabled right to suicide.

These overarching public policy objectives both justify and obligate Parliament to follow the lead of Oregon and Quebec and make *medically ascertained terminal illness* a condition for eligibility.

Rather than second guessing the outcome of potential future litigation, it is in the public interest for Parliament to uphold the public policy of preventing suicide rather than enlisting the medical profession as a proxy enabler of it.

Doctor – Patient Consent

Much attention has been focused on PAD being patient-focused rather than doctor-centred. This is a desirable goal in medical practice generally, and frameworks exist to ensure there is informed consent rather than coercion when it comes to treatment.

However, when it comes to PAD as contemplated in the Carter decision, focusing solely on patient consent misconstrues the situation. In this instance it is not the physician presenting treatment options to the patient in order to elicit his or her informed consent. Instead, *PAD is the option being proposed to the physician by the patient.* PAD clearly does not fall into the ordinary range of treatment options to be proposed to a patient by their doctor.

Accordingly, as and when the eligibility criteria are met, the party being asked to consent becomes the physician. At this point, the physician's choice whether or not to perform the requested procedure needs to be free from coercion in order for the principle of informed consent to be respected for doctor and patient alike. As was noted in the hearings, the Carter case involved a willing doctor and a willing patient - both are essential. Enabling the freedom to choose on the part of the physician does not derogate from patient-centred care.

The Benelux Experience

The evidence in the Benelux countries incontrovertibly shows that a regulatory regime which leaves decisions solely in the hands of physicians places vulnerable persons at risk of being put to death. Such a regime does not meet the stringent standards called for by the Court.

Evidence that the majority of physician-enabled deaths in Belgium have been performed by a handful of doctors ideologically committed to advancing this practice is especially alarming. Prior review safeguards are needed to prevent this kind of aggressive disregard of the individual circumstances of sufferers and their families. A regulatory regime that relies on post-facto self-reporting is powerless to prevent this kind of abuse.

Access

Concerns about access have surfaced as a major preoccupation of the Committee. The dedication of the necessary resources - such as teams for assessment, use of consent and capacity boards, referral of compliance to judges, provision of new specialists willing to carry out an approved death – these measures help avoid a tradeoff between safeguards and access. Delays in access to timely medical diagnosis and treatment, regrettably, are a fact of life for everyone in the medical system. Careful review to ensure all criteria for PAD are met in advance does not create a discriminatory burden.

Age of Consent & Advance Care Directives

In the case of age of consent the Committee has been rightly urged to stay with the explicit language of the decision and stipulate that PAD is only for consenting adults. Parliament is obligated to define that age in order to protect the young as a policy priority.

As has been frequently noted, Carter sets a floor rather than a ceiling. Thus there is nothing in the decision compelling Parliament to authorize PAD Advance Care Directives. On the contrary, its language and the specific circumstances of those who sought the relief in the Carter case require the decision to be the direct, personal, competent and uncoerced request of the individual at the time.

PAD: the Exception or the Rule?

The overarching question, which only Parliament can answer, is whether physician hastened death and the effective right to suicide are to be normalized, or remain options of last resort, and therefore carefully regulated. The Carter decision calls for careful and cautious legislated regulation.

Respectfully yours,

Jonathan Eayrs