

Submission to the Special Joint Committee on Physician-Assisted Dying by a Network of British Columbia Physicians

Introduction

We are a network of physicians in British Columbia (BC)¹ who are deeply concerned about the significant risks that physician-hastened death poses to vulnerable patients, Canadian society at large, and the conscience rights of health care professionals. Throughout this document, we will use the term “physician-hastened death” as recommended by the Canadian Society of Palliative Care Physicians, rather than the more ambiguous term “physician-assisted dying.”² We agree with the Supreme Court of Canada (SCC) ruling on *Carter v. Canada* that **a robust system of safeguards must be carefully designed and monitored in order to protect individual patient safety and the public good.** In her ruling, the original trial judge posited that the risks inherent in removing the criminal prohibition against physician-hastened death “can be identified and very substantially minimized through a carefully-designed system’ that imposes strict limits that are scrupulously monitored and enforced.”³ Risks inherent to PHD, such as involuntary physician-hastened death, are at best only minimized and not eliminated by the development of such safeguards. **We therefore advocate for the highest degree of rigour in developing a protective regime, such that the Charter rights of vulnerable patients to life, liberty, and security of person may receive due priority in the development of such policies. Further, we urge that strong, legally-binding, protective measures are needed to ensure that the Charter rights of physicians to freedom of conscience are fully protected.**

Our concerns merit representation at policy level, and we respectfully submit the following two measures as being necessary and prudent in forming a legislative response to *Carter v. Canada*:

- 1) Legislation that requires that all aspects of PHD take place in facilities solely designated for this purpose and completely separate from regular healthcare services.**
- 2) Legislation that articulates that physicians’ rights to freedom of conscience to not be compelled to participate in PHD, includes the right to abstain from participation at any level (performing, being trained to perform, referral to any party.)**

A system in which strict limits are enforced in protecting individuals and the public, is only possible if physician conscience rights are rigorously protected. No Canadian jurisdiction must be allowed to enforce mandatory participation at any level, including referral⁴ to a third party authority or organization. Coercion to refer, without due regard for clinical judgment, nullifies the value of a carefully designed process to determine appropriate eligibility for PHD. Patient access, patient protection, and

¹ A network of BC physicians with shared concerns regarding the February 2015 *Carter v. Canada* ruling participated as a stakeholder group in Direct Consultation with the Federal External Panel on Options for a Legislative Response to *Carter v. Canada*. As of January 2016, the original written submission has over 90 BC physician signatories, and may be accessed at: <http://www.networkofbcphysicians.ca>. This written brief to the Special Joint Committee on Physician-Assisted Dying represents an abridged and updated version of the original submission, and is submitted by the Steering Committee of this network.

² “Physician-hastened death” is the term endorsed by the Canadian Society of Palliative Care Physicians: <http://www.cspcp.ca/wp-content/uploads/2015/10/CSPCP-Key-Messages-FINAL.pdf>

³ *Carter v. Canada (Attorney General)*, 2015 Supreme Court of Canada 5. paragraph 27.

⁴ The association of referral with complicity is well-documented in bioethics discourse.

Fovargue, S. and M. Neal: “ ‘In Good Conscience’: Conscience-Based Exemptions and Proper Medical Treatment.” *Medical Law Review* 2015; 23:221-241.

physician conscience rights must be balanced to ensure patient safety. A more balanced system would not mandate referral but rather require all physicians who encounter a request for PHD **to inform the patient of all reasonable medical options, including the option of direct patient access to a separate central information, counselling, and referral service for PHD.**⁵ If Canadian citizens determine that PHD should be funded as part of our healthcare system, it then becomes the shared responsibility of society in general to ensure access, and not the responsibility of any one physician or health care authority. There is no precedent for mandatory referral in other countries where PHD has been decriminalised, and there is evidence that allowing conscientious objection to PHD has not resulted in obstruction of patient access to PHD.⁶

We maintain that PHD is not medical care per se and should not be codified as a medical procedure, but is rather a philosophical choice to terminate life as a means of addressing human suffering. The World Medical Association “strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.”⁷ Many Canadian physicians from diverse cultural backgrounds assert that PHD is not consistent with the core values of medicine.^{8,9,10,11} For this reason, as well as for protection of public interest, we submit that a strict regulatory regime is best achieved by requiring that all aspects of PHD take place in facilities solely designated for this purpose and completely separate from regular healthcare institutions and delivery of regular health services. We thoroughly endorse a recommendation that palliative care services be kept not only separate but exempt from providing PHD¹², consistent with the WHO definition of palliative care as

⁵ We support the Canadian Medical Association’s (CMA) call for the creation of a separate central information, counseling and referral service that patients who request PHD may directly access without physician referral. We endorse the CMA position on conscientious objection as articulated in the December 2015 CMA “Principles-based Recommendations for a Canadian Approach to Assisted Dying” in section 5.2: “Conscientious objection by a physician: Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or participate in it or refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no discrimination against a physician who chooses not to provide or participate in assisted dying.” The College of Physicians and Surgeons of British Columbia’s recently approved policy “Interim Guidance on Physician-Assisted Dying” likewise clearly articulates that physicians are not required to make a formal referral for PHD.

⁶ For example, at the August 26th, 2015, Canadian Medical Protective Association (CMPA) panel session on End of Life Care, a Dutch senior policy advisor with the Royal Dutch Medical Association noted that conscientious objection has not resulted in obstruction to patient access to PHD in the Netherlands and that referral for PHD is not mandatory. We believe that a policy of mandatory referral would not meet the Oakes test of minimally impairing physician Charter rights, since other jurisdictions have demonstrated that patient access can be achieved without a policy of forced referral.

⁷ World Medical Association: *WMA Resolution on Euthanasia*. World Medical Association; 2013. Available: <http://www.wma.net/en/30publications/10policies/e13b> (accessed 2015 Dec 22.)

⁸ Lau, T. and R. Leiva: “We need a moral compass.” *CMAJ* 2015; 187:757.

⁹ Slawnych, M. et al: “*Carter v. Canada*.” *CMAJ* 2015; 187: 911-912.

¹⁰ Chapman, D.B.: “Death: Natural or hastened.” *BCMJ* 2015; 57:325.

¹¹ Al-Awamer, A. “Physician-assisted suicide is not a failure of palliative care.” *Can Fam Physician* 2015; 61: 1045-1047.

¹² At CMA General Council 2015, delegates passed a motion stating that “The Canadian Medical Association recognizes that the practice of assisted death as defined by the Supreme Court of Canada is distinct from the practice of palliative care.”

being a discipline that “intends neither to hasten or postpone death.”¹³ In order to maintain cultural diversity among medical practitioners, and considering that the majority of Canadian physicians are not currently willing to perform PHD,¹⁴ physicians with a conscientious objection to PHD must be allowed to practice medicine without coercion to refer for or perform this act. This measure would help to protect the culture of medicine as a discipline in which physicians continue to have a fiduciary responsibility to apply best standards of practice to all patients, so that vulnerable patients need not fear discrimination from societal perception that their lives are less worthy of costly medical intervention. Patients who would not choose PHD as an option must continue to have access to regular health care services without fear of a wrongful death. We strongly believe that all these concerns are best addressed by keeping PHD separate from the regular delivery of health care services.

Our position is grounded both in the SCC ruling itself and in medical codes of ethics that have been in place since the foundation of modern medicine. The SCC ruling specifies that:

“nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid... a physician’s decision to participate in assisted dying is a matter of conscience”¹⁵

In stating that the SCC ruling does not “compel physicians to provide assistance in dying” and “simply renders the criminal prohibition invalid” for a “stringently limited, carefully monitored system of exceptions,”¹⁶ the ruling is clear that PHD is to be the exception, and not the rule. There is therefore at most a “negative right”¹⁷ to not have PHD result in criminal prosecution in very limited situations in which patients meet SCC criteria and have a physician willing to perform PHD. The ruling does *not* imply a “positive right” for individuals to demand state provision of this procedure to all who request it. In contradiction to the SCC ruling, some physician regulatory bodies and PHD advocacy groups describe access to PHD as a positive patient right, and have even advised mandatory referral,¹⁸ illustrating the almost inevitable push to expand these practices. The mere legal permissibility of a procedure is not sufficient to prove either a collective duty on the profession or an individual duty on a particular physician to ensure that any given patient is able to have access to such a procedure.¹⁹

Some physicians advocate for expansion of access to PHD well beyond the criteria stipulated by the SCC ruling (e.g. to mature minors and those not currently competent). However, the CMA’s 2014 updated policy on euthanasia and assisted death states that “[t]here are *rare* [emphasis added] occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate.”²⁰ The spirit of this policy is therefore one of conceding to the possibility of rare exceptions within legal constraints, and is

¹³ WHO definition of palliative care: <http://www.who.int/cancer/palliative/definition/en/>

¹⁴ A 2015 CMA poll revealed that 63% of physicians responding would not be willing to perform PHD.

¹⁵ *Carter v. Canada*, para 132.

¹⁶ *Carter v. Canada*, para 29.

¹⁷ While positive rights oblige action, negative rights oblige inaction. In this case, a negative right with respect to PHD would oblige inaction in terms of criminal prosecution.

¹⁸ College of Physicians and Surgeons of Ontario’s Draft Interim Guidance on Physician-Assisted Death, December 2015; Quebec’s Bill 52: An Act respecting end-of-life care, 2014.

¹⁹ Parker, J.C.: “Conscience and Collective Duties: Do Medical Professionals Have a Collective Duty to Ensure That Their Profession Provides Non-discriminatory Access to All Medical Services?” *J of Medicine and Philosophy* 2001; 36:28-52.

²⁰ CMA 2014 policy on euthanasia and assisted death.

consistent with our recommendation that such exceptions be kept distinct from regular health care services.

Eligibility criteria and definition of key terms:

The eligibility criteria described in the SCC ruling have been subjected to overly permissive interpretation. We advocate for legislation that articulates interpretation of key terms that would **exclude most non-terminal illness, disability, and PHD based on purely psychological suffering**. We also urge that **eligibility should not be extended to mature minors, nor by advance directive nor through substitute decision-makers to those who are not competent at the time of PHD**. Legislation could fulfill the SCC mandate of a regime that “imposes strict limits”²¹ by clearly defining key eligibility terms with “stringently limited”²² parameters. **We propose the following such definitions:**

Adult person: a person who is of the age of majority, thereby clarifying that provincial legislation permitting consent of mature minors does not apply to the practice of PHD.

Competent: referring to competency at the time PHD is performed, thereby excluding consent by advance directive or by a substitute decision-maker.

Grievous: referring to a medical condition graded as being at minimum “severe” or “end-stage” by objective medical assessment.

Enduring suffering: suffering that has persisted of sufficient duration to have extended past a waiting time considered acceptable given the natural history of the patient’s particular illness, disease, or disability.

Physician-assisted dying: is an inappropriate euphemism when used to refer to the contentious practices of physician-assisted suicide and euthanasia, We endorse the Canadian Society of Palliative Care Physicians’ submission of “physician-hastened death” as a more appropriate term that may help safeguard against confusing medical terminology that is detrimental to patient care. Not only “physician-assisted death”, but also such terms as “medical aid in dying”, and “end-of-life care” should not be used in referring to physician-hastened death as these also lead to the false conflation of PHD with medical practices endorsed by the profession such as palliative care and withdrawal or refusal of treatment in the minds of patients, the public, and even many health care professionals. The use of imprecise and confusing terms puts these patients at risk of wrongful death or of mistakenly refusing appropriate medical services (e.g. palliative care) due to fear of wrongful death.

Risks to individuals and society associated with physician-hastened death: We outline below risks inherent to removing the criminal prohibition against PHD, noting that such risks are heightened in the absence of legislation that robustly protects physician rights to abstain from participating in PHD. Risks may only become apparent in later years, and therefore a properly designed system of safeguards must prove robust over successive generations in order to be effective in protecting individuals and the public for the long-term.

Risks to individual patients and society at large:

²¹ *Carter v. Canada*, para 27.

²² *Carter v. Canada*, para 29.

- 1) Wrongful death from a patient consenting to PHD in a time of weakness²³
- 2) Wrongful death from a patient having his or her life terminated without explicit consent:²⁴
Surveys of statistics in Belgium and the Netherlands conclusively and repeatedly demonstrate that at least 24% of PHD in these countries occurs without explicit patient consent. ^{25, 26}
Extrapolating the Belgian rate of PHD without explicit consent of 1.7% of total deaths to the Canadian population would make this the 9th leading cause of death in the country, accounting for over 4,000 deaths per year in which patients are killed without their consent. This is a major threat to patient autonomy and public safety.
- 3) Decreased access to regular health care services due to a patient with a fear of wrongful death declining to receive services in an institution or centre that performs or refers for PHD
- 4) Decreased access to regular health services due to difficulty in recruitment/retention of physicians in fields of medicine affected by coerced physician participation in PHD
- 5) Individuals who oppose PHD being under-represented in the forming of policy and delivery of health services in a system that discriminates against their beliefs
- 6) Increased discrimination against individuals with significant illness, disease, or disability through societal devaluing of the worth of the lives of these individuals based on the rationale that such lives could merit termination according to the SCC ruling.
- 7) Physical and/or psychological suffering from incomplete or unsuccessful attempts at PHD
- 8) Increased psychological suffering and financial hardship of family members, caregivers, and friends of individuals with significant illness, disease, or disability due to 1-7
- 9) Expansion of eligibility criteria for PHD evidenced in other jurisdictions, with elderly and disabled populations being particularly at risk of discrimination or negative shifts in medical practice standards that disadvantage vulnerable populations.^{27 28 29}

²³ According to the original trial judge, this was the intent of the criminal prohibition against assisted suicide – “the protection of vulnerable persons from being induced to commit suicide at a time of weakness” *Carter v. Canada*, para 29.

²⁴ Chambaere, K. et al: “Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium.” *NEJM* 2015; 372:1179-1180. This recent study documented PHD as representing 6.3% of all deaths in Flanders, Belgium, in 2013. 1.7% of all deaths occurred without explicit consent. Applying Statistics Canada 2014 data to these percentages (2011 figures with total deaths numbered at 242,074 deaths) would result in 15,250 PHD deaths overall, ranking higher than the 4th leading cause of death. PHD without explicit request alone would total 4,115, therefore ranking in between the 8th and 9th leading causes of death by these figures.

²⁵ Van der Heide et al.: “End of Life Practices in the Netherlands under the Euthanasia Act.” *NEJM* 2007; 356:1957-65.

²⁶ Chambaere, K. et al: "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" *CMAJ* 2010; 183: 895- 901.

²⁷ Boer, T. “Boer: I was wrong – euthanasia has a slippery slope.” *The Calgary Herald*; 2014 July 17. Available at: <http://calgaryherald.com/opinion/boer-i-was-wrong-euthanasia-has-a-slippery-slope> (accessed 2016 Jan 28)

²⁸ Physicians’ Alliance Against Euthanasia: “*Open Letter to the Canadian People on Euthanasia and Assisted Suicide.*” 2014. Available at: <http://collectifmedecins.org/en/open-letter/>

²⁹ Z. Zyllicz, a Dutch physician, notes: “...this society needs to be aware that euthanasia seems to have unintended but significant social costs.... A general practitioner requested my assistance for a very sick patient with metastasized rectal cancer. The patient refused surgery and had been discharged home. One week later, he developed nausea and began to vomit fecal fluid. The general practitioner attended very quickly and proposed readmission to hospital, but the patient refused, thinking he might be pressed to consider an operation. The general practitioner, not knowing what to do next, proposed a good death, Submission to the Special Joint Committee on Physician-Assisted Dying by a network of BC physicians January 30, 2016

- 10) Negative impact on the culture of medicine, due to decreased cultural diversity among practising Canadian physicians resulting from a lack of support for conscientious objection to PHD
- 11) Suicide contagion in general among the public.³⁰

Risks to individual physicians and physician trainees (i.e. medical students, residents) influence societal risks as policies that discriminate against or do not adequately protect the rights of physicians with conscientious objection to PHD will eventually result in a shift in the cultural and ideological landscape among medical practitioners:

- 1) Violation of physician Charter rights to freedom of conscience through coercion by provincial physician regulatory bodies or provincial health authorities for physicians with conscientious objection to PHD to perform or refer for this procedure. Compromising freedom of conscience not only harms physicians but also compromises patient care and erodes the fiduciary nature of the doctor-patient relationship.³¹
- 2) Violation of physician-trainee Charter rights to freedom of conscience through coercion by medical school faculties for medical students and residents to be trained to perform PHD, thereby coercing these trainees to perform PHD in the process³²

meaning euthanasia. The patient, however, was a practicing Roman Catholic and refused this offer. The general practitioner phoned me for advice, saying, ‘Usually I solve this kind of problem with euthanasia, but this patient seems to not be pleased by this.’

I gave the physician our protocol for the relief of bowel obstruction, and he was pleased to be able to ease his patient’s distress.

The physician’s remark that he usually solves such problems with euthanasia is disturbing. It illustrates how euthanasia becomes a substitute for learning how to relieve the suffering of dying patients.” (p. 140-142)

Zylicz, Z. (2002) Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician. In K. Foley & H. Hendin (Eds.) *The Case Against Assisted Suicide: For the Right to End-of-Life Care*. Baltimore, Maryland: The John Hopkins University Press. (pp.122–143).

³⁰ Tousignant, M. et al: “The impact of media coverage of the suicide of a well-known Quebec reporter: the case of Gaetan Girouard.” *Social Science & Medicine* 2005; 60: 1919-1926. Available at: http://www.preventionsuicide.info/files/Article_Tousignant_Mishara_%20al.pdf. (accessed 2016 Jan 28)

³¹ “Acting against one’s conscience is a discomfoting experience; and some hold that it is a link to the core moral values that are an essential part of an individual’s sense of self – so called moral integrity. Breaching these core values harms that sense of self, resulting in a loss of self-respect, feelings of discontent, and ultimately desensitization of the conscience. This does not just harm the practitioner; the healthcare disciplines require intensive partnership between the professional and their patients, and persistently acting against one’s conscience has been identified by practitioners as resulting in burnout and by researchers as resulting in desensitization to patient suffering.”

Birchly, G.: “A clear case for conscience in healthcare practice.” *J Med Ethics* 2012; 38:13-17. (p. 16)

³² “Health care is a deeply hierarchical institution, and individuals, particularly those who are relatively junior in the hierarchy, may feel significant pressure to participate in activities they feel are morally
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- 3) Inappropriate discipline and/or punitive measures by either provincial regulatory bodies or medical school faculties for physicians or trainees with conscientious objection to perform or refer for PHD
- 4) Employment or training program entry discrimination for physicians/medical trainees with a conscientious objection to PHD, due to potential hiring/admission constraints at institutions required to provide PHD, referral for PHD, or training in PHD
- 5) Physicians and trainees without conscientious objection to PHD experiencing greater burden of workload due to adverse recruitment and retention of physicians and trainees in fields of medicine most affected by PHD or in provinces where physician rights to conscientious objection are not adequately supported

Legislative recommendations: We advocate for the following measures and safeguards as being essential to minimizing risks inherent to PHD, and consistent with both the February 2015 SCC ruling on *Carter v. Canada* and Canadian medical codes of ethics:

- 1) **Legislation that requires that all aspects of PHD take place in facilities solely designated for this purpose and completely separate from regular healthcare services.** This requirement of patient transfer to a separate PHD service that is distinct both in location and organizational structure would reduce the risk of termination of life without request or adequate consent, and would also preserve the team unity of existing healthcare facilities.
- 2) **Legislation that protects physician freedom of conscience and professional judgment to abstain from referral or performance of PHD without fear of reprisal or discrimination,** namely:
 - a. Legislation that explicitly details that the conscience rights of physicians, physician trainees, and allied health care workers to not participate in PHD includes the right to not perform, be trained to perform or refer for PHD to any individual, organization, or governmental authority.
 - b. Legislation that protects physicians, physician trainees, allied health care workers, institutions, and organizations who choose to not participate in PHD from discrimination, particularly individual employment or institutional funding discrimination.
- 3) **Legislation that requires that assessment of eligibility for PHD be a carefully-designed system that involves the following safeguards – with priority on the creation of a separate central multidisciplinary service:**
 - a. **A separate central multidisciplinary information, counselling, and referral service for PHD which patients may access directly without physician referral would best support patient autonomy and the standard set by the SCC that patients are assessed by physicians who are “properly qualified and experienced”³³ in making assessments**

repugnant. I claim a right to object conscientiously protects individuals from participation in immoral acts they lack the institutional power to challenge effectively.”

Birchly, G. (p. 16)

³³ “The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all

regarding capacity for voluntary consent. Such a service should be required to meticulously document that diagnosis, prognosis, and all other reasonable options have been discussed with the patient and that the reasons for the request have been carefully explored through counselling.

- b. A duty for a physician who encounters a patient request for PHD to inform the patient of all other reasonable medical options and document that these have been offered and that the reasons for the request have been carefully explored, before providing further information regarding PHD, including informing the patient that access to the separate central service does not involve physician referral
- c. All enduring requests for PHD be directed to a court of law for consideration, so that all cases will receive judicial review in determining whether the SCC exemption may be applied, thus meeting the “highest level”³⁴ of scrutiny mandated in determining coercion, patient competency, and criteria eligibility. Patients could choose to directly self-refer to this route of access as well.
- d. Policies that forbid physician-initiated or team-initiated counsel of PHD as an option for a particular patient, requiring the physician to verify by documentation that discussion of PHD as an option was initiated by the patient. PHD must not be brought up routinely by anyone in the healthcare team in discussing options of end of life care.³⁵ This policy must be strictly enforced.
- e. Requiring both oral and written consent as part of the process of informed consent, and that two witnesses be present at the time of consent, neither of whom can be the attending physician, a person entitled to a portion of the patient’s estate, or a person who is an employee of a facility designated to provide PHD.
- f. Requiring that a cooling off period or waiting period between the time of the first request for PHD and final assessment of capacity and eligibility be of sufficient time to diagnose potential psychiatric conditions that may affect capacity. Careful consideration should be given to implementing a system that has waiting periods proportional to the estimated amount of life to be lost. E.g. a request for PHD from a patient who very recently became paraplegic should likely have a much longer waiting period than someone within days or weeks of an expected death.
- g. Requiring that psychiatric assessment be a default measure in assessing requests for PHD, with a duty to demonstrate that psychiatric assessment is not necessary before proceeding

be reliably assessed as part of that process (paras. 795-98, 815, 837, and 843). In reaching this conclusion, she particularly relied on the evidence on the application of the informed consent standard in other medical decision-making in Canada, including end-of-life decision-making (para. 1368). She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity (para. 831).” *Carter v. Canada*, para 106.

³⁴ We submit that the “highest level” of scrutiny called for by the trial judge (*BCSC Carter v. Canada*, para 1240) would by current standards involve not only two physicians, but a multidisciplinary team dedicated to PHD assessment and the rigour of scrutiny of a court of law in detecting coercion, undue influence, and ambivalence.

³⁵ This measure would clarify that physician-initiated counsel of PHD as an option for a particular patient remains criminally prosecutable under section 241(a) of the criminal code.

with a PHD request that has not been scrutinized by psychiatric consultation³⁶.

4) **Legislation that protects patients from coercion, undue influence, or physician abandonment in the administration of PHD:**

- a. In the case of physician-assisted suicide (or “patient-administered PHD”), requiring that the physician who writes the prescription for PHD be the on-call physician responsible for dealing with any complications resulting from ingestion. Other physicians (e.g. emergency room physicians) would therefore not be called on to “complete” unsuccessful attempts at PHD. A dispassionate witness should be present at the time of ingestion in order to prevent coercion or abuse by another party.
- b. In the case of euthanasia (or “physician-administered PHD”), requiring that the physician who administers lethal injection be present at the time of death and remain with the patient until death has been documented, in order to avoid patient abandonment in case of complications from PHD.

5) **Legislation that upholds rigorous standards of documentation, tracking, and review of all PHD cases, including the following directives:**

- a. **A federal mandate that the death certificates of patients dying by PHD reflect the true cause of death as being PHD** for accuracy of reporting and monitoring. A specially-designated death certificate with mandatory fields would allow for accurate statistics on such descriptors as the underlying medical condition justifying PHD, facility in which PHD is performed, physician performing PHD. The physician providing PHD should be responsible for filling out the death certificate, and these practices should be monitored at least as carefully as the prescription of opiate medications.
- b. **A federal mandate that documentation of all cases of PHD must be kept indefinitely for quality assurance purposes and that all cases must be reviewed by a multidisciplinary board.** Such a board must have independent review and research as part of its mandate, with the public and stakeholders having on-going input in this process. In-depth, scrupulous data collection and analysis must be carried out by an independent agency.
- c. **A federal multidisciplinary board or oversight body be responsible for monitoring physician compliance with regulations:** usual physician discipline measures must be

³⁶ Regarding assessment in Oregon, “doubts exist about full compliance with the requirement for referral to a mental health professional of patients suffering from a psychological or psychiatric disorder or depression causing impaired judgment. . . It seems unlikely that persons suffering from Major Depressive Disorder or depression causing impaired judgment would both have the persistence and will-power to work their way through the approval process for assisted death, and escape detection by the reviewing physicians. However, the evidence (from the Ganzini Depression Study) suggests that up to three persons in Oregon may have done so.” (*BCSC Carter v. Canada*, paras 649, 670.)

followed when required in addressing possible negligence or abuses.³⁷

Conclusion

The original intent of the February 2015 SCC ruling was to provide for a “stringently limited, carefully monitored system of exceptions”³⁸ that would allow an extremely small minority of Canadian citizens to terminate their lives by PHD, while protecting both the larger majority of vulnerable people for whom this would constitute wrongful death and the public from societal harm. In the development of policies and procedures towards that end, it is therefore important to remember that the SCC decriminalized PHD in Canada as an “exception” in very limited situations, not as a rule or positive right for patients to demand state provision of this procedure for a broad range of indications. **Federal legislation to clarify these matters is urgently needed to protect vulnerable patients and the ethical practice of medicine in Canada. A critical safeguard is to require that all aspects of PHD be carried out in facilities specially designated for this purpose and completely separate from regular medical services.** Because PHD is now permissible due to a change in the criminal code (federal jurisdiction), this requirement for separate facilities should form the foundation for federal regulations to ensure equity of both protection and access across Canada. **Direct patient access, by means of a separate central information and referral service or by application to a court of law, shows the most promise for ensuring both patient safety and appropriate access to the procedure. Finally, the protection of physician Charter rights to freedom of conscience—including the right to abstain from referral for PHD—is essential to developing meaningful safeguards. Since the SCC has placed its confidence in the ability of physicians to determine who may qualify for PHD,³⁹ it is incumbent upon governments and regulators who are responsible for patient safety to give these same physicians the freedom to apply professional judgment without coercion or undue interference.** We understand that the rationale for removing the criminal prohibition against PHD was carried out with the good intent of affirming the rights of a small minority of individuals in Canada to have their fear of harm and suffering be addressed in a manner consistent with their personal autonomy and wishes. As the Special Joint Committee on Physician-Assisted Dying deliberates options presented on a legislative response to *Carter v. Canada*, **we simply ask that the rights of vulnerable patients, the rights of the Canadian public at large, and our personal and professional autonomy as Canadian physicians, be likewise upheld in addressing legitimate fears of individual and societal harm.**

Respectfully submitted by the Steering Committee of a network of BC physicians:⁴⁰

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Dr. Luke Chen, MD, FRCPC, MMed ; Dr. Sherry Chan, MD, CCFP

³⁷ The trial judge noted that the effectiveness of safeguards depends on “the extent to which compliance with the safeguards is monitored and enforced.” (*BCSC Carter v. Canada*, para 1239)

³⁸ *Carter v. Canada*, para 29.

³⁹ *Carter v. Canada*, para 106.

⁴⁰The Network of BC Physicians is a grassroots network of over 90 BC physician signatories of a joint written submission to the Federal External Panel on Options for a Legislative Response to *Carter v. Canada*. Submission to the Special Joint Committee on Physician-Assisted Dying by a network of BC physicians
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