Proposals Regarding Certain Provisions of Bill C-7

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Introduction

As a member of Quebec's Commission on End-of-Life Care, I, along with some of my colleagues, recently appeared before the House of Commons Standing Committee on Justice and Human Rights. During this appearance, we presented the Commission's view on certain amendments proposed in Bill C-7 and the five-year experience of the Commission. In addition, I heard the testimony of other stakeholders. Based on my professional experience and my time on the Commission, I believe it is appropriate to express some of my concerns regarding the legislative framework for medical assistance in dying in Canada.

In any case, legislators legalizing medical assistance in dying need to do the following:

- establish clearly defined eligibility criteria that are consistent with the *Canadian Charter of Rights and Freedoms*;
- ensure that robust safeguards that can protect the most vulnerable people are in place;
- provide that, in every case, a person's decision to receive medical assistance in dying is not only informed and free of all external pressure, but also considered;
- prevent a person from receiving medical assistance in dying for unserious, temporary or transient reasons, without being paternalistic;
- be able to capture, in real time, the abuses that may occur through a systematic review of all cases where medical assistance in dying is provided; and
- provide for mechanisms to report to society on the current state and evolution of medical assistance in dying.

Regarding the amendments proposed by Bill C-7, I fundamentally agree with the removal of the 10-day waiting period, the inclusion of the final consent waiver, the elimination of the reasonably foreseeable death criterion and the reduction in the number of independent witnesses.

As for the two sets of safeguards proposed, I agree that two sets of measures that apply depending on whether or not natural death is reasonably foreseeable should be established. Indeed, I believe the proposed safeguards could be strengthened.

First, I would point to Belgium's euthanasia law, enacted in 2002, which includes two sets of safeguards that apply depending on whether the death of the person requesting euthanasia is considered imminent or not. In general, the Belgian legislation provides that the first doctor, or medical practitioner, to receive a request for euthanasia must, as under the Canadian legislation, consult **another medical practitioner, the second doctor**, about the grievous and irremediable nature of the condition, specifying the reason for the consultation. The consulting medical practitioner reviews the medical record, examines the patient and verifies that the physical or psychological suffering is enduring, intolerable and unrelievable.

In addition, under the Belgian legislation, if the medical practitioner who receives a request for euthanasia believes that the death of the patient—whether an adult or emancipated minor—is obviously not imminent, the practitioner must then consult **another medical practitioner, the third doctor**, a psychiatrist or a specialist in the relevant pathology, specifying the reason for the consultation. The consulting practitioner reviews the medical record, examines the patient, verifies that the physical or psychological suffering is enduring, intolerable and unrelievable, and confirms that the request is voluntary, **considered** and repeated. In addition, the legislation prescribes a **30-day** waiting period between the initial request and the provision of euthanasia.

The safeguards in Bill C-7 do not go as far as those in the Belgian legislation in that the use of a third specialist doctor, in addition to the first two medical practitioners, is not included. However, the bill does provide, subject to an exception, a 90-day waiting period between the first assessment and the provision of medical assistance in dying where the person's natural death is not reasonably foreseeable.

I realize that some doctors and legal experts argue there should not be two sets of safeguards depending on whether or not a person's natural death is reasonably foreseeable, as this would be contrary to the Charter and the principle of equality before the law. This is the source of their fierce opposition to implementing two sets of safeguards and to the exclusion of mental illness.

That said, I would like to relate our **concerns** regarding individuals whose natural death is not reasonably foreseeable but who are likely to make a request for medical assistance in dying. Some of these individuals will be people with one or more serious disabilities, people experiencing the immediate shock of a very recent serious diagnosis indicating they will die within a certain time, people whose polypathologies will make them suffer for a long time before causing their death, people with early-stage neurodegenerative diseases who will die over the short, medium or long term, and people with a combination of physical disease and mental illness. In the future, medical assistance in dying could be considered for mental illness alone (after Bill C-7).

Unlike in cases of imminent foreseeable death, the judgment and clinical decisions of requesters and providers of medical assistance in dying become increasingly complex depending on the expected remaining lifespan. This inevitable gray area calls for more precautions and safeguards, especially for the most vulnerable. That is why I support Bill C-7's proposal to create two sets of safeguards.

Proposals

Accordingly, I would like to propose the following:

Maintain the two sets of safeguards and add the referral to a third medical practitioner for assessment as in Belgium.

I cannot emphasize enough the importance of having different safeguards depending on whether or not a person's natural death is reasonably foreseeable, and even of considering including a third medical practitioner with expertise in the person's disease to assess the person. We understand that Bill C-7 does not include the referral to a third doctor but instead requires one of the two medical practitioners assessing a person whose natural death is not reasonably foreseeable to have expertise in the condition causing the person's suffering.

That said, we believe it would be appropriate to consider including a third doctor, as in the Belgian legislation, recognizing that this proposal could spark criticism from lawyers, doctors and other individuals, as well as organizations pushing for less state and legislative intervention in a decision they see as essentially personal, one that should be between a person and that person's doctor.

Make the clinical presentation a requirement of the federal monitoring regime.

As regards monitoring, it is important to collect data that furnish not only statistics, but also an appropriate clinical presentation of cases of medical assistance in dying. In Quebec, the official medical assistance in dying declaration form requires the doctor to provide a summary but complete clinical presentation of the condition of the person to whom the doctor provided medical assistance in dying. This requirement enables a better assessment of cases of medical assistance in dying. I believe this information should be among the data collected under the federal monitoring regime.

Conclusion

In conclusion, we propose that Bill C-7, beyond its amendments removing the 10-day waiting period, including the final consent waiver, eliminating the reasonably foreseeable natural death criterion, reducing the number of independent witnesses and creating two sets of safeguards depending on whether or not natural death is reasonably foreseeable, be amended as follows:

Eligibility criteria for medical assistance in dying

- Amend section 241.2 (1) to read as follows:

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
(a) (b) (c)
(d) they have made a voluntary and considered request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

Safeguards

Amend section 241.2 (3.1) to read as follows:

Before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, the medical practitioner or nurse practitioner must
(a) (b) (c) (d)

(e) ensure that another medical practitioner or nurse practitioner and a third medical practitioner or nurse practitioner with expertise in the condition that is causing the person's suffering have provided a written opinion that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the two other medical practitioners or nurse practitioners referred to in paragraph (e) are independent;

Filing information — practitioners

Amend section 241.31 (1) to read as follows:

241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who carries out an assessment of whether a person meets the criteria set out in subsection 241.2(1) or who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information, including the complete clinical presentation that led to the medical assistance in dying, required by those regulations to the recipient designated in those regulations.