

Brief of the

Association for Reformed Political Action (ARPA) Canada

to

The House of Commons Standing Committee on Justice and Human Rights

regarding

Bill C-7, An Act to amend the Criminal Code (medical assistance in dying)

November 12, 2020



The main problem with Bill C-7

Medical assistance in dying (MAiD) is fundamentally different from any other medical service. Advising someone to obtain chemotherapy or pain medication is not a crime, but advising or encouraging someone to end their own life is still a crime. If MAiD were simply another health care service, it would not be before this Committee today because medical services are not regulated by the *Criminal Code*. Regulating the practice of medicine in general does not fall within Parliament's criminal law power. This Committee is wrestling with the question of when to permit some people to kill others who desire to die. That is why this is before Parliament.

Bill C-7 is flippant in its treatment of the deliberate termination of human lives. It seems primarily designed to make MAiD providers' jobs easier, rather than to ensure the full and equal protection in law of every member of the human family, regardless of disability, disease, or age, and to steer people away from assisted suicide and toward life-affirming treatments and supports as much as possible. Canada's current law, as amended by Bill C-14, is already being interpreted to allow doctors to euthanize patients who likely have a decade or more to live. The law already fails to prevent doctors from suggesting MAiD without being asked, which sends a powerful message to the sick and disabled that a doctor thinks their lives are not worth living. Bill C-7 fails to address the current problems under Bill C-14, as identified by the UN Special Rapporteur on the rights of persons with disabilities, among others, and even makes them worse.

Bill C-7 represents a radical change in Canada's law on assisted suicide / consensual homicide. It shifts from permitting MAiD in a limited end-of-life context, as an alternative to a drawn-out, difficult death, to offering it as a final escape from a difficult life or difficult period of life. Everyone will die, but only people with disabilities or chronic illness will be offered assisted death as a solution for suffering. The able-bodied who suffer will only be offered suicide prevention and various other supports. Society's message – particularly from our legal and medical systems – will be that some lives matter more than others. Parliament should abandon this bill and, instead, push back against the misguided *Truchon* decision by re-enacting an end-of-life criterion together with a clear statement of Parliament's objective in doing so, namely to prohibit euthanizing persons who are not dying as ethically and legally wrong.

Particular problems with Bill C-7

1. Discrimination against people with disabilities and chronic illness

Bill C-7's preamble notes that "Canada is a State Party to the United Nations Convention on the Rights of Persons with Disabilities," and that "Parliament affirms the inherent and equal value of every person's life and of taking a human-rights based approach to disability inclusion."

The UN Convention emphasizes that persons with disabilities are entitled to the same protections and benefits of the law *without distinction*.¹ The UN Convention contemplates special *accommodations and supports* as necessary to ensure persons with disabilities enjoy the same rights as others. Bill C-7, conversely, contemplates offering disabled people a "solution" to their

¹ See e.g. Sections 2 and 3 of the [Preamble](#), and Articles 5, 10, 12, and 25.



suffering – deliberately induced death – that we would not offer to the suffering able-bodied. This is disability-based discrimination.

2. A double standard on psychological suffering

Psychological suffering alone should not make a person eligible for MAiD. Psychological suffering can never be considered definitively irremediable, as psychiatrist Dr. John Maher [explains](#).² Bill C-7 clarifies that “mental illness” is not a “grievous and irremediable medical condition” and therefore cannot, on its own, make a person with mental illness eligible for MAiD. However, if a person has an illness, disease, or disability (s. 241.2(2)(a)) that causes her “psychological suffering” that is unbearable to her (subjective standard), that person will be eligible for MAiD under Bill C-7.

So, for example, this means that a person who is depressed after being paralyzed in a recent accident, but who is not suffering physical pain, will be eligible for MAiD, but a person who is depressed about losing a family member in an accident will not be eligible for MAiD. The latter person, instead of being offered MAiD, will only and continually be offered mental health support. We should offer mental health treatment and community supports to both.

3. Euthanasia, quick and easy

If Bill C-7 passes, it will be legally permissible for a person with a serious illness to walk into their doctor’s office, have their doctor suggest MAiD as an option for them, have the doctor’s secretary pop in to witness a written request for MAiD, and be killed as soon as a second opinion is acquired, possibly the same day. The doctor would have to mention other options, of course, but that is just a basic rule of informed consent. That is the fast and easy track.

The “slow track” is not much better. For those in the ambiguous category where natural death is not reasonably foreseeable, Bill C-7 says that other options must be discussed and consultations with service providers must be offered. Such basic steps should be required in “fast track” cases as well. Therefore, paras. 241.2(3.1)(g) and (h) of Bill C-7 should be added to the existing subsection 241.2(3) as well. Further, these provisions should be strengthened. It is not enough that a patient has been “offered consultations” with professionals who can help them. Before a person is euthanized, their doctor should be required to proactively facilitate meetings with other professionals who may be able to help their patient live well.

4. Cutting the 10-day waiting period will cost lives

As for the 10-day waiting period in the “fast track,” it is irresponsible to eliminate it as Bill C-7 would. Dr. Madeline Li, expert witness in the *Lamb* case in B.C., developed and oversees the MAiD program at the University Health Network in Toronto. She notes in her expert report that psychological suffering is the main reason for assisted dying requests in all jurisdictions where it is legal (para. 6 on p. 5). Dr. Li describes the case of a woman who had bone cancer and a history of chronic depression (see paras. 20-21). This patient was assessed by two “experienced MAiD

² *CBC News*, Feb. 11, 2020, “Why legalizing medically assisted dying for people with mental illness is misguided.”



providers” (not by her oncologist or psychiatrist) who approved her for MAiD. After her 10-day waiting period, she changed her mind and decided to pursue a palliative approach. Later, during another medical crisis, she requested MAiD again. Her MAiD physician decided that there were no concerns about her apparent ambivalence. But two days before her planned MAiD intervention, she changed her mind again and agreed to undertake new cancer therapies. This illustrates, Dr. Li says, the difficulty of accounting for the influence of anxiety or depression and other factors in a patient's request for MAiD. It also demonstrates the importance of waiting periods, and of offering all possible supports to a patient.

Air Canada and other airlines give you 24 hours to cancel your flight penalty-free. Bill C-7, however, would permit a person to request MAiD and be euthanized the same day or hour. It is not at all clear why the government thought deleting this safeguard was necessary.

5. Increasingly broad interpretations of *reasonably foreseeable natural death* means people with years to live will end up on the “fast track”

Bill C-14 (2016) made *reasonably foreseeable natural death* (RFND) an eligibility criterion for MAiD. As the Justice Department explained at that time, the bill was intended to limit MAiD to the end-of-life context, which is also why they chose the term “medical assistance in *dying*”.

However, Bill C-14 noted that RFND did not require a specific prognosis as to how much time a patient likely had left to live, which some other countries or states that have legalized MAiD have included. The government likely avoided this for two reasons: 1. Political – to placate MPs who might think the bill was too restrictive, and 2. Legal – to guard the bill against court challenges by avoiding a prognosis-based eligibility criterion that a judge might consider arbitrary.

However, since Bill C-7 would expand MAiD to those without RFND, these reasons for not setting a specific time prognosis would be removed, or at least reduced in significance. If your natural death is not reasonably foreseeable, under Bill C-7 it would simply mean that you enjoy more safeguards, including the benefit of a 90-day waiting period – it would not mean you are ineligible.

One reason adding a time prognosis to Bill C-7 is so important is that MAiD providers quickly became quite liberal in their interpretation of the NFRD criterion, with some even [boasting publicly](#) that they have euthanized patients who likely had a decade or more to live.³ Most MAiD deaths are caused by a small number of physicians who have no ethical objection to killing patients. It should not surprise us, then, that they will take a liberal approach to interpreting this law when it is plain that they can get away with it (we have not found any instances of prosecution).

Dr. Li writes in her expert report in the *Lamb* case:

While there was more caution in using shorter prognoses for interpreting reasonably foreseeable natural death in the first year [after MAiD was legalized in 2016], following the CAMAP

³ Dr. Wiebe, who has euthanized several hundred people, says she goes by a roughly 10-year prognosis – a very loose standard from a scientific and medical perspective. See Joan Bryden, “Experts Concerned Ottawa has revived uncertainty over meaning of foreseeable death in assisted dying bill,” *Globe and Mail*, March 3, 2020, online.



Reasonably Foreseeable Clinical Practice Guideline and the A.B. v Canada [re. elderly patient with advanced osteoarthritis, but not terminal] determination, some clinicians gained comfort with extending prognostic timeframes out to many years. [...]

The law as it stands contains enough flexibility in the interpretation of the end of life criteria that it is not a barrier for practitioners who are comfortable with expanding access to MAiD.... Some have commented that the flexibility in interpreting what constitutes a reasonably foreseeable natural death render the criterion meaningless as a safeguard for vulnerable patients. Rather than removing this criterion, this safeguard could be strengthened by the addition of specific prognostic requirements. [emphasis added]

If a time prognosis is not added, it would mean that a patient who has years – possibly more than a decade, depending on which doctor you ask – of life ahead of her, could nevertheless be sent down the “fast track” toward MAiD laid out in subsection 241.2(3) – as amended and weakened by Bill C-7 – rather than the “slow track” Bill C-7 would add in a new subsection 241.2(3.1). If you have years left ahead of you, then surely there is time to find you a health care provider with expertise in your condition (as s. 241.2(3.1)(e) requires), and to discuss available mental health and community services available to you (as s. 241.2(3.1)(g) and (h) require) before killing you. A sensible time prognosis might be RFND within 6 months.

6. The 90-day waiting period is not what you think

As for the 90-day waiting period, the Canadian Society of Palliative Care Physicians has noted that it is an insufficient amount of time to find satisfactory ways to manage a person’s symptoms or to help them adjust to an illness or disability. We share this concern. We would also point out that the 90-day waiting period itself is ambiguous, given that it begins not on the day a written request is signed (as with the current 10-day waiting period), but on the day the doctor begins to assess a patient’s eligibility, which could be months before a patient actually requests MAiD.

The problem is that we cannot know with certainty the day on which the assessment for eligibility began. Did it begin on the day that MAiD first came up in a conversation? Or the day the physician first began to consider whether his patient’s condition was “grievous and irremediable”? Keep in mind that the written request for MAiD must be made *after* a medical practitioner has informed you that you have a grievous and irremediable condition. You may decide not to make a written request for MAiD until three months later, but the doctor may have begun (and largely completed) assessing your eligibility for MAiD three months earlier. This needs to be clarified in Bill C-7. The most straight-forward amendment would be to add a clarification that the 90-day waiting period begins the day the patient makes a written, signed, and witnessed request for MAiD.

7. The “waiver of final consent” provisions in Bill C-7 are reckless

Bill C-7 would permit (in s. 241.3(3.2)) a “written arrangement” granting medical practitioners the authority to unilaterally decide – with no second opinion and no witnesses – when a patient has lost capacity to give or withhold consent to medical care and to kill the patient at that time (provided capacity is lost *before* a date specified in the written arrangement). Unlike a written request for MAiD, which currently requires two witnesses (Bill C-7 would reduce that to one), a



subsequent “written arrangement” granting a medical practitioner a license to kill the patient requires no witnesses or second medical opinion.

To be clear, there is no requirement for any witnesses or second medical opinion:

1. when the “written arrangement” for waiver of final consent is formed;
2. when the practitioner decides to warn the patient of “risk of losing capacity” ((3.2)(a)(iii));
3. when the practitioner decides the patient has lost capacity ((3.2)(b)); or
4. when the practitioner kills the patient.

Subsections 241.3(3.2) – (3.4) contemplate euthanizing a person who, fearful of the possibility of losing capacity, entered a written arrangement with their doctor (without witnesses) wherein the doctor may unilaterally decide when the person has lost capacity. Further, these sections contemplate that a patient *might possibly* demonstrate refusal to be killed after seeming to have lost capacity – ss. (3.3) and (3.4) – but that the practitioner need not be try to give the patient any opportunity to do so. Best to kill them while they sleep, then, or simply sedate them first.

The preamble to Bill C-7 notes the “inherent risks and complexity” of allowing people to waive contemporaneous consent to being killed, yet it establishes *no safeguards or oversight for the use of this mechanism whatsoever*. The preamble also notes that Parliament’s review of the MAiD laws scheduled for later this year “may include issues of advance requests” – yet Bill C-7 is charging ahead with a form of advance requests before Parliament’s scheduled review.

8. Cutting witness requirements puts convenience over safety and accountability

Bill C-7 would apply a one-witness requirement whether one’s natural death is reasonably foreseeable or not – meaning the issue is not the time it takes to find two witnesses. The value of two witnesses, of course, is that if anything suspicious emerges about the circumstances of a patient’s MAiD request, the account of two witnesses can be compared. A person needs two witnesses to create a last will and testament. Surely it is not too much to ask to have two witnesses sign a request to have a medical practitioner euthanize someone.

Bill C-7 also lowers the bar for who qualifies as an *independent* witness. It allows medical practitioners or others who are paid to provide health care or personal care, including someone who provides care to the person who is requesting MAiD. The danger here is that medical personnel or support workers who approve of and grow accustomed to MAiD, or who work for a MAiD provider, may be routinely relied on to be the *sole witness*.

Bill C-14 (2016) did not prevent a MAiD provider’s staff from being the witness, provided they are not “directly involved” in the patient’s care. Therefore, we suggest the following addition to s. **241.2(5)**: ... (e) are supervised in their work by either medical practitioner involved in assessing the patient’s eligibility for MAiD.



Leading patients toward MAiD

The preamble to Bill C-14 (2016) noted one of its goals as protecting vulnerable people from being “induced” to end their lives. The preamble of Bill C-7 (2020) says the same. Yet both bills do little to prevent such “inducement.” Neither prohibits a medical practitioner from mentioning (and thus implicitly suggesting) MAiD to a patient without first being asked. In fact, neither bill clearly prohibits counselling or encouraging a person to seek a “medically assisted death.” This should be prohibited generally, and medical personnel in particular should be prohibited from mentioning or discussing MAiD as an option for a patient without being explicitly asked by the patient.

MAiD providers typically say that their patients never feel induced or pressured to choose MAiD, and often feel pressure (especially from family members) not to choose MAiD. However, there are plenty of individual accounts of patients being offered MAiD without asking for it. Though these typically go unreported in the media, they deserve to be heard and taken seriously. Moreover, the problem was noted in an official UN Report. In the “[End of Mission Statement](#)” (April 12, 2019) of the UN Special Rapporteur on the Rights of Persons with Disabilities, there are many items requiring a government response. Canada has several major shortcomings when it comes to caring for persons with disabilities. With respect to MAiD, the Rapporteur says:

I am extremely concerned about the implementation of the legislation on medical assistance in dying from a disability perspective. I have been informed that there is no protocol in place to demonstrate that persons with disabilities have been provided with viable alternatives when eligible for assistive dying. I have further received worrisome claims about persons with disabilities in institutions being pressured to seek medical assistance in dying, and practitioners not formally reporting cases involving persons with disabilities. I urge the federal government to investigate these complaints and put into place adequate safeguards [...].

This “Statement” was followed up by the UN Rapporteur’s full [Report on the visit to Canada](#) (Dec. 19, 2019), which notes:

The recent judgment of the Superior Court of Quebec [[Truchon](#)] might put additional pressure on persons with disabilities who are in a vulnerable situation due to insufficient community support. As many persons with disabilities said during the visit, they are being offered the “choice” between a nursing home and medical assistance in dying.

While it may appear to MAiD providers that their patients are not choosing a medically induced death because of outside pressure, in reality there are myriad subtle factors that can shape a person’s desire to die. Dr. Madeline Li noted in her expert report in the *Lamb* case that psychological suffering is the main reason for assisted dying requests in all legal jurisdictions. People may feel a sense of hopelessness, or lack of purpose, or despair. They may feel that they are a burden on loved ones and society, or fear becoming a burden. They may imbibe the cultural narrative that a less independent life is one not worth living. All of these concerns can be addressed without recourse to ending the life of the patient.



Expanding MAiD is *not* constitutionally required

The *Carter* (2015 SCC 5) ruling was very limited in scope. The Court based its decision on the factual situation of Ms. Taylor, the plaintiff in *Carter* who had ALS, a fatal neurodegenerative disease. The Court refers to Ms. Taylor, “persons like her,” and “persons in her position” throughout its judgement, as did the trial judge. The Court’s *Charter* analysis is bookended by two key statements:

1. “For the reasons below, we conclude that the prohibition [...] infringes the right to life, liberty, and security of Ms. Taylor and of persons in her position” (para 56).
2. After deciding the *Charter* issues and immediately following the declaration of the law’s invalidity, the judgment states: “The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought” (para 127).

The lone judge who decided the *Truchon* case failed to appreciate this and failed to recognize Parliament’s objectives in limiting MAiD to the end-of-life context. The ruling should have been appealed. Never before has Parliament amended the criminal law at the behest of a single, lower court judge. It is the responsibility of this Committee to listen to the concerns of all parties, including disability rights advocates, palliative care physicians, and others, to be clear about its objectives in limiting MAiD, and to enact more responsible, life-affirming policies.

Respectfully submitted,

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