

# FEDERAL and PROVINCIAL RESPONSIBILITIES to IMPLEMENT PHYSICIAN ASSISTED SUICIDE



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# Background

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- The legality of physician assisted suicide [PAS] has been resolved by SCC in *Carter v. Canada*
- Physician assisted dying is a much broader topic
- Only example of a Supreme Court legalizing PAS
- All other jurisdictions acted by legislative fiat
- Supreme Court in Colombia, in December 2014, imposed on government a requirement that the rights of persons with disabilities be protected by having a regime requiring prior authorization by a review board before a physician is entitled to assist a person to commit suicide.

# Rationale

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- The Supreme Court in *Carter* reversed *Rodriguez* because it determined that it would be possible for Parliament to develop SAFEGUARDS adequate to protect people who are VULNERABLE.
- The Court provided general CRITERIA for establishing eligibility, but expressly left it to Parliament to develop SAFEGUARDS sufficient to protect people who are VULNERABLE.
- The right to assisted suicide is based on respecting an adult's informed and voluntary CHOICE to commit suicide with physician assistance, but only if the person is experiencing SUFFERING that is objectively and subjectively verifiable based in the person's illness or disability.

# Background to Appended Draft Legislature

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- Appended bill addresses areas of **FEDERAL RESPONSIBILITY**
- Acknowledge contribution of collaborator on project, Gilbert Sharpe, whose experience working with both federal and provincial governments on the Mental Disorder amendments to the Criminal Code has been invaluable.
- Quickest way to identify most **PROVINCIAL RESPONSIBILITIES** is to consider the implementation of the amended NCR procedures.
- PAS requires the provision of palliative and home care and ensuring counselling is available to ensure alternatives are identified to ensure informed decision.
- Compassion requires not only a right to physician assisted suicide, but coincidentally, the right to treatment and alternatives to alleviating suffering.

# Overview of Legislation

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1. Witnessed application from person contemplating suicide
2. Role of responsible and consulting physician
3. Role of counsellor – “vulnerable person”
4. Involvement of family
5. Medical record
6. Potential intervention of Public Guardian and Trustee
7. Review Board role and decision-making
8. Role of assisting physician
9. Safeguards under draft Bill expands and enhances rights of person contemplating assisted suicide compared to the minimal safeguards in comparator jurisdictions.

# Rationale Defines Scope

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- Section 21 “aiding and abetting” remains unchanged
- Section 22 “counselling” remains unchanged

Q: If physician assisted suicide is a “benefit ”or “medically necessary treatment” [i.e. therapeutic] how will legal challenges on behalf of children, or incapable persons with neurological, developmental or emotional disabilities be resolved?

Q: Can criminal/civil sanctions of physicians/counsellors be anticipated if persons are deprived of the assisted suicide safeguards under the Criminal Code and suicide prevention programs?

# Criterion 1

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- The law preventing a person from receiving the assistance of a physician to commit suicide has been struck down where:
  1. The person is “grievously and irremediably ill”

Q: Does this include all persons with disabilities?

Q: What of persons with psychological illness?

# Criterion 2

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2. The person is experiencing “enduring suffering: that is “intolerable to the individual”

Q: Must the suffering arise from the illness/disability and not from factors that motivate non-disabled persons to contemplate suicide?

Q: What must be demonstrated to objectively distinguish “psychological suffering” from being “tired of living”?



# Criterion 3

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- It does not matter if the suffering results from a person refusing interventions that would alleviate the suffering [para. 27]

Q: Is refusal relevant to assessments of “mental capacity” or “vulnerability”?

Q: Can a person “refuse” an intervention [e.g. palliative or home care] which is not actually available to him/her?

Q: How can suffering be “intolerable” if the person chooses to tolerate it?

# Definitions Required

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- The words used by the Court are open to broad and various interpretations.
- They require statutory definition capable of consistent application

Q: Is it relevant that the case was argued and decided on the premise that only a small number of cases will trigger “physician assisted suicide”?

# Safeguards

1. The Court did not prescribe “safeguards” and states at para. 117 that it assumes a “carefully designed and monitored system of safeguards” will be put in place
2. The Court expresses the expectation at para. 125 that Parliament will craft a “complex regulatory scheme”
3. The 3 comparators considered when the Court concluded that effective safeguards could be put in place offer little guidance because (1) Oregon has the 6 month criteria; and (2) and (3) the Benelux countries are described as “permissive regimes” with “different medico-legal cultures” [para. 112-113]

# Vulnerability

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- Vulnerability is not precisely the same as “criteria”
- The safeguards are not only intended to identify whether a person meets the criteria, but also to protect persons while or if they are vulnerable.
- Just as the Court did not prescribe “safeguards,” it did not define who is so vulnerable as to require protection.
- Everyone who is contemplating suicide can be considered “vulnerable” to a degree. THEREFORE vulnerability is not an absolute prohibition.
- Rather the safeguards should contain a process that will enable the person to make their choice after their vulnerability has been addressed to the extent possible, or after their temporary period of vulnerability has passed.

# Who is Vulnerable?

- Tom Shakespeare is a UK disability activist whose opinions were heavily relied upon by Ms. Carter and BC Civil Liberties Association.
- His evidence characterized vulnerability as “essential safeguards”.
  1. “If assisted suicide were to be legalized, appropriate safeguards would be necessary to protect vulnerable people and prevent abuse”. (p.129)
  2. “First, disabled people and terminally ill people need to have access to independent living and the full range of support services. Choices about death should not be made because life has been made unbearable through lack of choices and control.” (p.129)

# Shakespeare Safeguards (cont'd)

3. Without a commitment to providing palliative care it “makes it more likely for dying people to end their lives prematurely...” (p.129)
4. “It is an important principle that the qualification for assisted suicide is the end stage of incurable disease accompanied by unbearable suffering. Simply being a disabled person is not a reason to be permitted assisted suicide.” (p.130)
5. “... people who have recently developed or been diagnosed with impairment or terminal illness should be prevented from exercising the choice of assisted suicide. There should be a short-term infringement of autonomy for newly disabled people, until they come to terms with their situation.” (p. 130)

[His short chapter on safeguards is appended]

# Is Vulnerability Being Addressed?

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- In the comparator jurisdictions reviewed by the Court, the only record we have of the reasons why those who died sought a physician assisted death from the persons themselves comes from Oregon Health Services records. [Carter para. 400]

End of life concerns	2010 (N=65)	1998-2009 (N=460)	Total (N=525)
Losing autonomy (%)	61 (93.8)	414 (90.8)	475 (91.2)
Less able to engage in activities making life enjoyable (%)	61 (93.8)	398 (87.3)	459 (88.1)
Loss of dignity (%) <sup>§</sup>	51 (78.5)	282 (85.2)	333 (84.1)
Losing control of bodily functions (%)	30 (46.2)	264 (57.9)	294 (56.4)
Burden on family, friends/caregivers (%)	17 (26.2)	167 (36.6)	184 (35.3)
Inadequate pain control or concern about it (%)	10 (15.4)	101 (22.1)	111 (21.3)
Financial implications of treatment (%)	1 (1.5)	12 (2.6)	13 (2.5)

- It is difficult to distinguish all but the penultimate “concern” from those that would arise for any person feeling overwhelmed by the onset of disability.

- In the Benelux Countries the number of deaths by assisted suicide/euthanasia is increasing exponentially. According to data cited by the trial judge (para. 475 and 578) updated by the Netherlands Annual and Belgium Biannual Reports, and dropping out the first [incomplete] year, the number of PAS deaths has increased 64.13% annually in the Netherlands and 47.77% in Belgium.

[the relevant data is appended]



# Review Before or After Death ?

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- In these comparator countries the decision is made by the doctor(s) behind closed doors and without any prior external review. After the issuance or administration of the lethal medication the doctor fills out a form and submits it to a panel for *ex post facto* review.
- All the forms submitted to date have been found to be compliant.
- There is no record kept of the prior efforts made to address or attempt to address either the medical factors underlying the person's suffering or factors contributing to the person's vulnerability.
- Many doctors in these jurisdictions are unwilling to perform the role of "judge, jury and executioner." By default these roles have fallen to a small cadre of physicians.
- The exponential increases noted, particularly in the Benelux countries, suggests that the criteria being applied by this group of physicians is steadily expanding. *Ex post facto* review appears powerless to curb this "criterion creep"

# The Solution

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- A process of prior review requires the requisite health care and services addressing vulnerability to be engaged, to ensure the choice to die is based on accurate and complete information [informed].
- A system of prior review encourages the physician who knows the person best, normally the family or attending physician, to remain involved.
- A review board chaired by a Superior Court Judge, aided by members with appropriate medical and lay expertise substitutes consistent and reviewable decision-making for the *ad hoc* decision-making of a small group of assisted suicide “specialists”.
- A “Dr. Donald Low” expedited process should be available for exceptional circumstance so that a process, estimated to take approximately 45 days, will not frustrate the compassionate objectives identified by the Court.