Court File No. 35591

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION AND GLORIA TAYLOR

APPELLANTS
(Respondents/Cross-Appellants)

- and -

ATTORNEY GENERAL OF CANADA

RESPONDENT
(Appellant)

- and–

ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENT
(Appellant)

RESPONSE TO THE MOTION TO THE COURT (COUNCIL OF CANADIANS WITH DISABILITIES AND THE CANADIAN ASSOCIATION FOR COMMUNITY LIVING, INTERVENER)
(Pursuant to Rule 54 of the *Rules of the Supreme Court of Canada)*

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TAB 1

Court File No. 35591

IN THE SUPREME COURT OF CANADA
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RESPONSE TO THE MOTION TO THE COURT (COUNCIL OF CANADIANS WITH DISABILITIES AND THE CANADIAN ASSOCIATION FOR COMMUNITY LIVING, INTERVENER)

PART I – STATEMENT OF FACTS

A. Background

1. The Council of Canadians with Disabilities ["CCD"] and the Canadian Association for Community Living ["CACL"] are the major cross-disability and voluntary disability organizations in Canada respectively. They each have been granted intervener status to represent the interests of Canadians with disabilities in cases before this Court on numerous occasions. CCD and CACL were jointly represented as interveners in this case before both the British Columbia Court of Appeal and in the Supreme Court of Canada in this case. They did not intervene at trial in either *Carter* or its discontinued companion case out of Quebec called *Leblanc*.

2. The right at issue in *Carter* was physician assisted suicide and voluntary euthanasia, which shall be referenced as PAS/VE.[1] Physician assisted dying is a defined term in Quebec's Bill 52[2] as including palliative care as well as PAS/VE. As noted in *D'Amico*, in order to avoid euphemisms in areas where fundamental rights are engaged it is best to use language with precision.[3]

3. The overriding issue in *Carter* was whether or not it was possible to enact legislative safeguards sufficient to protect the vulnerable from ending their life in times of weakness. The Court in *Rodriguez* said it was not.[4] In *Carter* the Court concluded that it was possible and reversed itself, holding that "the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards".[5] Having found that that s. 241(b) and s.14 of the *Criminal Code* violated Ms. Taylor's s. 7 rights to life, liberty and security of the person, its finding concerning safeguards meant this infringement could not be justified or saved by s. 1.

4. The Court established core criteria for PAS/VE in its declaration and then qualified those criteria with the statement that:

> The scope of this declaration is intended to respond to the factual circumstances in this case. It makes no

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[1] Canadian Association for Community Living, "A Proposed Framework for Vulnerability Assessment: to regulate access to physician-assisted suicide and voluntary euthanasia in Canada" (December 2015), at p. 2-4.

[2] *An Act respecting end-of-life care*, RSQ, c. S-32.0001; David Baker & Rebeka Lauks, "Federal and Provincial Responsibilities to Implement Physician Assisted Suicide" (Forthcoming February 2016) Health Law in Canada.

[3] *D'Amico et Saba c Procureure Generale du Quebec*, 2015 QCCS 5556, at para. 122; and Affidavit of Michael Bach, dated December 9, 2015, at para. 8 [Affidavit of Michael Bach].

[4] *Rodriguez v British Columbia (Attorney General)*, [1993] 2 S.C.R. 519, at pp. 581, 607, 610.

[5] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, at paras. 74, 117, 123 [*Carter*].

pronouncement on other situations where physician-assisted dying may be sought.[6]

5. Leaving aside the qualifying language, the criteria established by the Court will require statutory elaboration so that they can be consistently interpreted and applied. Absent that elaboration, physicians could adopt a broad range of interpretations of the Court's language[7] producing widely varying outcomes in individual circumstances if, as appears likely, the federal and provincial governments are unable to respond legislatively and administratively to the Court's judgment prior to February 7, 2016.

6. In its decision the Court recognized that if "a carefully designed and monitored system of safeguards will be put in place" the "risks associated with physician-assisted death can be limited".[8] The Court further anticipates that allowing courts to grant constitutional exemptions based on the criteria established by the Court "would create uncertainty, undermine the rule of law and usurp Parliament's role".[9] It stated instead that "Parliament must be given the opportunity to craft an appropriate remedy" and that "[c]omplex regulatory regimes are better created by Parliament than by the courts".[10]

7. The Court recognized that it was possible for Parliament to avoid uncertainty, uphold the rule of law and exercise its proper function by enacting legislation, presumably in collaboration with its provincial partners, which give effect to the *Charter* right

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[6] *Carter*, at para. 127.
[7] See for example the language used in *Carter*, at paras. 126-28.
[8] *Carter*, at para. 117.
[9] *Carter*, at para. 125.
[10] *Carter*, at para. 125.

declared by the Court to exist, while establishing a complex regulatory regime of safeguards designed to protect people during times when they are vulnerable.

8. As indicated, the Court determined that this was not a proper case for a constitutional exemption and expressly declined to authorize the granting of constitutional exemptions during the period while the declaration was suspended because Ms. Gloria Taylor had by that time passed away.[11]

B. Safeguards in Other Jurisdictions

9. The conclusion that effective legislative safeguards are possible was based in significant measure upon the trial judge's review of comparator jurisdictions. Nevertheless it cannot be assumed that the Court in upholding this conclusion of the trial judge was therefore endorsing or even recommending any particular system of safeguards. On the contrary the Court made it clear that making this decision was appropriately within the purview of Parliament. It also carefully noted relevant differences between the jurisdictions it reviewed and Canada which made the holus bolus adoption of their safeguards inadvisable.

10. The safeguards in the American states which have legislated PAS have little applicability because their criteria are expressly restricted to persons with terminal conditions who are expected to die within 6 months. As a consequence those accessing PAS in these jurisdictions are primarily cancer patients most of whom were

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[11] *Carter*, at paras. 124, 129.

already receiving hospice care. It is possible that the criteria established by the Court in its declaration will not be so restricted.[12]

11. With respect to the Benelux countries, the Court elected not to reverse, based on Professor Montero's affidavit, the trial judge's findings about the possibility of legislating Canadian safeguards which are sufficiently vigorous. That conclusion was not based on any one jurisdiction, or set of jurisdictions, and was not based exclusively on foreign experience in any event. The Court did state that it shared the trial judge's view that the Benelux countries represented "permissive regimes" with "different medico-legal cultures".[13] The culture was based in part on permissive attitudes on the part of the medical profession, with which elected representatives chose not to interfere, and also the fact that each of these countries has comprehensive palliative and home care programs unlike Canada. For that reason, this Court said that the "cases [described by Professor Montero] offer little insight into how a Canadian regime might operate".[14]

12. The Court and the AGC in her submissions appear to have been unaware that Colombia, the only other country apart from Canada in which PAS has been legalized by its Supreme Court back, decided in December 2014 that safeguards based on medical decision making alone were inadequate and violated the rights of persons with disabilities and directed that an adjudicative review take place to decide

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[12] *Carter v Canada (Attorney General)*, 2012 BCSC 886, at para. 1393.
[13] *Carter*, at para. 112.
[14] *Carter*, at para. 113.

eligibility for PAS.[15] The government of Colombia amended its safeguards to address the concerns of that country's Supreme Constitutional Court in May 2015. This comparator was not available to either the trial judge or this Court. The means there is now a comparator jurisdiction which relies upon prior review rather than the *ex post facto* monitoring utilized in the Benelux countries.

PART II – SUBMISSIONS ON EXTENSION

13. CCD and CACL support the request made by the federal government, on behalf of itself and the provinces, for an order extending the suspension of constitutional invalidity of ss. 14 and 241(b) of the *Criminal Code* for a further 6 months. It is clear it was never the intention of this Court that its declaration take effect in the absence of federal legislation. The Court has conferred a constitutional right to PAS/VE but premised its decision on the assumption a statutorily based system of safeguards had been put in place. We are now advised by the federal government, together with its provincial-territorial partners, that this is not going to happen by February 7, 2016.

14. Without commenting on the pace at which consultations, research and drafting have been taking place at both the federal and provincial-territorial level, CCD and CACL note that this is a completely different situation from the *Morgentaler*[16] case where Parliament and the provinces decided that no legislative action be taken pursuant to the Court's declaration of Constitutional invalidity. The only possible conclusion was that it was Parliament's intention that abortion be made available to Canadian women

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[15] Motion Record of the Respondent/Applicant, the Attorney General of Canada (Motion to Suspend), dated December 3, 2015, at para 13 [Attorney General of Canada's Motion to Suspend]; citations for Colombian cases and the Revised Guidelines are at Affidavit of Michael Bach Exhibit "C".

[16] *R v Morgentaler,* [1988] 1 SCR 30, at pp. 58-59, 67.

on demand, which was the outcome. While some respected civil liberties and dying with dignity organizations have asserted that parallels exist with this case, there is no basis to conclude on the basis of the evidence before this Court that the failure of Parliament to meet this Court's February 6th deadline represents a decision to accede to these groups' request that PAS/VE be made available to Canadians with disabilities upon demand, and without safeguards. That was not the issue before the Court in *Carter* and that is not what this Court decided. On the contrary the express finding of the Trial Court, upheld by this Court, was that safeguards were essential and that PAS/VE without safeguards would endanger the lives of persons with disabilities.

15. Parliament is now fully engaged in a process of considering its responsibility for establishing safeguards and is committed to working with provincial-territorial governments to implement a process that reflects the importance of properly balancing the unobstructed access of persons to PAS/VE and the need to ensure that clear criterion are consistently applied through a system of safeguards that will adequately safeguard the interests of persons while vulnerable.

16. CCD and CACL concur with the AGC that allowing the declaration to come into effect would result in "uncertainty with respect to the remedy granted by the Court".[17] Medical practitioners would be authorized proceed on the basis of their individual interpretation of the Court's criteria, some of which, including the words of qualification, may be open to widely divergent interpretation.

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[17] Attorney General of Canada's Motion to Suspend, at para. 23.

17. There is a valid question of whether the right the Court has declared was intended to be contingent upon safeguards existing, in which case it may be incumbent upon the Court to enact safeguards if it is concluded that the government of Canada has failed without legitimate excuse to do so. This is the practical effect of what the government of the province of Quebec has urged upon the Court.[18]

18. CCD and CACL concur with the AGC that refusing to extend the suspension of this Court's declaration would result in a failure to address the rights of "vulnerable individuals, including persons with disabilities".[19] Whether or not fault can be found on the part of others for the delay in responding to the Supreme Court's judgment, the fault does not lie with persons with disabilities, yet it is they who would pay the price if the suspension of this Court's declaration is not granted. CCD and CACL, together with many other organizations representing the interests of persons with disabilities have been active from the outset in these discussions. They have made reasoned submissions to all levels of government, and have commissioned the development of Draft Legislation that has been widely distributed for consultation commencing in June 2015.[20] It recognizes the Court has not set for itself the task of declaring what safeguards must be in place, but CACL in the absence of the Federal and Provincial-Territorial Panel Reports, scheduled for release December 15 and 14 respectively, wishes to lay before the Court information about the kinds of issues that Parliament is being asked to by CACL to consider in order to better appreciate the complexity and fundamental rights at issue.

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[18] Réponse de la Procureure Général du Québec Concernant la Demande de Réaudition Du Procureur Général du Canada Relativement à une Prolongation de Délai, dated December 8, 2015.
[19] Attorney General of Canada's Motion to Suspend, at para. 20.
[20] Affidavit of Michael Bach at paras. 21-22.

19. CCD and CACL take the position that the safeguards they propose involving a prior adjudicative review, rather than leaving the decision in the first instance to physicians, involving as it does complex legislation, consultation with provincial and territorial governments and an implementation process, could never have been implemented within a year. Maybe the Benelux model could have been up and running in a year, and maybe Parliament would be forced, in the absence of any alternative, to adopt such a model if it were required to have something in place by February 6, 2016. Since the Court expressly left the decision about safeguards to Parliament, it is submitted that refusing the extension requested would "generate uncertainty, undermine the rule of law and usurp Parliament's role".[21]

20. That does not mean that the Court is powerless to act, if it were satisfied that the federal government had not acted with sufficient diligence to implement its Order, or if it determines that it would violate the *Charter* to leave persons without access to PAS/VE any longer, CCD and CACL urge that the appropriate remedy would be to grant a constitutional exemption following receipt of oral submissions from interested parties. CCD and CACL have every confidence that a Superior Court judge, armed with this Court's reasons in *Carter* would afford a process, which would ensure application of the Court's criteria in a manner that ensures reasonable interim access to PAS/VE and the protection of vulnerable persons during times of weakness. While acknowledging that such a process would be less accessible than the flexible process of review proposed by CCD and CACL, it would be infinitely preferable to the chaos and dangers that would result from simply allowing the suspension to lapse.

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[21] *Carter* at para. 125.

PART III – ORDER SOUGHT

21. CCD and CACL request that the requested extension be granted.

22. In the alternative they request that if this Honourable Court decides to authorize constitutional exemptions or to allow the suspension to lapse, that no lapse or exemption be authorized until the parties and interveners have the opportunity to address the Court on the issue of safeguards to be established during the period leading up to the enactment of federal legislation.

Dated: December 10, 2015

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PART IV – AUTHORITIES

Case Law		Referred to at paragraph
1.	*An Act respecting end-of-life care*, RSQ, c. S-32.0001	2
2.	*D'Amico et Saba c Procureure Generale du Quebec*, 2015 QCCS 5556	2
3.	*Rodriguez v British Columbia (Attorney General)*, [1993] 2 S.C.R. 519	3
4.	*Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331	3,4, 5, 6, 8, 11, 19
5.	*Carter v Canada (Attorney General)*, 2012 BCSC 886, at para 1393.	10
6.	*R v Morgentaler,* [1988] 1 SCR 30, at pp. 58-59, 67.	14

TAB 2

Court File No. 35591

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION AND GLORIA TAYLOR

APPELLANTS
(Respondents/Cross-Appellants)

- and -

ATTORNEY GENERAL OF CANADA

RESPONDENT
(Appellant)

- and–

ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENT
(Appellant)

AFFIDAVIT OF MICHAEL BACH

I, Michael Bach, Executive Vice-President of the Canadian Association for Community Living, in the City of Toronto, in the Province of Ontario, AFFIRM AND SAY AS FOLLOWS:

1. I am Executive Vice-President of the Canadian Association for Community Living ("CACL") and as such have personal knowledge of the matters described in this affidavit. I affirm this affidavit on behalf of the Canadian Association for Community Living.

Overview

2. CACL makes this submission in support of the motion by the Attorney General for Canada to extend for a further 6 months the suspension of the declaration of constitutional invalidity of ss.14 and 241 (b) of the Criminal Code.

3. CACL believes that detailed consideration is necessary of a more robust system of safeguards than the current private patient-physician consent process ("Benelux model") allows, and dimensions of which are discussed below. Because such a system was not canvassed, as the Benelux model was in the Court's judgment in *Carter*, and because such a system would be more challenging to implement, it cannot be thrown into place on February 6, 2016; and it will take time to for Parliament to review it. If it was Parliament's preferred option, it would require consultation with provincial-territorial partners. CACL fully realizes that it is not this Court's issue to decide, but feel obliged to provide the Court with the following information in order to persuade the Court that its system of safeguards meets some hypothetical threshold of merit sufficient to warrant granting an extension so there is even a possibility that Parliament could give it serious consideration.

4. Evidence submitted in the *Carter* case pointed to the fact that persons who become disabled through traumatic injury or illness very often consider suicide, and openly question whether they would have survived a period of despair if physician assisted suicide/voluntary euthanasia (PAS/VE) had been available to them at the time. In the absence of a more robust system of safeguards there is very real likelihood that such outcomes will result once these interventions are legalized. CACL fully respects the

Court's decision in *Carter* and respects the right to access PAS/VE on the strict criteria laid out. However, we remain concerned that the social bases of respect, solidarity and social cohesion which are so essential to ensuring life quality especially for people with significant disabilities will be further undermined. We outline below how this could happen, drawing on evidence from other jurisdictions.

5. *Carter* makes clear that the parameters of the *Criminal Code* prohibition continue to be constitutionally valid legislative measures insofar as they are designed to protect "vulnerable persons from being induced to commit suicide at a time of weakness."[1] CACL believes that administering these legislative measures requires a set of safeguards, protocols and procedures in the health care system for managing the distinction between those who require protection of the prohibition and those who do not. In any particular case, this will not necessarily be an easy line to draw and needs effective assessment tools for this purpose (for an example, see the CACL's, "A Proposed Framework for Vulnerability Assessment: to regulate access to physician-assisted suicide and voluntary euthanasia in Canada" attached as Exhibit "A").

6. CACL believes additional time is needed beyond the February 6, 2016 deadline for public consideration of the findings and recommendations of both the Federal External Panel and the Provincial-Territorial Expert Advisory Group on this matter, the reports of neither have yet been publicly released. CACL is also concerned that without an extension there will be insufficient time and opportunity for a considered review and discussion of the extensive proposals CACL and others have developed to safeguard vulnerable persons from being induced to commit suicide in a time of

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[1] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331, at para 29 [*Carter*].

weakness, and to protect such persons from abuse and error in the health care system, and from taking their own lives.

7. As well, time will be required by federal and provincial/territorial governments, health professionals, regulators and other stakeholders to arrive at a coherent framework for safeguards once the Federal and Provincial-Territorial panel reports are released. Once a decision is reached on the framework, time will also be needed for the necessary training, policy development and any re-organization in the health care system required to begin managing requests for PAS/VE in a safe manner. Without these steps, there is a very real likelihood that the Benelux model will prevail as the default and out of desperation. In CACL's opinion this will result in the death of some persons who are vulnerable to being induced to commit suicide in times of weakness and will also substantially harm the prospects for people with disabilities to be recognized, and to recognize themselves, as fully valued, respected and contributing members of Canadian society.

Rationale for Additional Safeguards for Physician-Assisted Suicide and Voluntary Euthanasia in Comparison to Refusal or Withdrawal of Life-Sustaining Treatment

8. CACL respects the Supreme Court of Canada's decision in *Carter v. Canada,* to recognize a right to assisted suicide and voluntary euthanasia (PAS/VE). CACL distinguishes "physician-assisted suicide and voluntary euthanasia", from the more general term of "physician-assisted dying". We do this because physician-assisted dying can encompass a wide range of palliative care interventions, many of which are currently available through the health care system; issues of access aside. For the purposes of law

and policy reform we urge continued use of the original terms related to suicide and euthanasia, in no small part because, unlike other health care interventions, they must also be regulated in light of the *Criminal Code* prohibition that stays in place to protect vulnerable persons, including both persons with disabilities and those without. In doing so, we do not wish to be provocative or to polarize discussion about this sensitive topic. Rather, we want to be very clear about the interventions that need public policy, dialogue and decision post the *Carter* decision in light of their unique legal context and status.

9. It should also be noted that in a purely descriptive sense, a person's request for PAS/VE must be based on that person's suicidal ideation and intent – a person's wish to die – in order for the request to be given serious consideration. Where a patient with a traumatic injury proposes refusing life sustaining treatment, as is very frequent when people become disabled and/or receive a serious prognosis, he or she is not left with their physician to make this decision in isolation. Unlike PAS/VE, this generally arises in a hospital setting where the patient is surrounded by social workers, rehabilitation therapists and case managers who work night and day to help that patient come to grips with their despair and suffering over their disability and to assist them to understand the life they can lead with accommodation and support in our caring and interdependent society. This is not traditionally regarded as part of the "informed consent process" but it does not mean that it is not a crucial part of the information the person requires before giving or withholding informed consent. Looking at the physician-patient interaction in isolation from the multi-disciplinary supports designed to address the patients vulnerability is an impoverished and formalistic way of regarding the support that is provided to a potentially suicidal patient.

10. If the patient does not respond to these efforts, every hospital and many community agencies have protocols for responding to patients with suicidal ideation and intent. These are of growing concern in health care systems and examples of protocols for application in the Canadian, U.S. and U.K. contexts are referenced in Exhibit "A", at pp. 5-7. Such protocols are operative in health care systems in Canada, having been developed by the Ontario Hospital Association and the Canadian Patient Safety Institute for example, and involve sensitive attention to the multi-factoral nature of the ideation and intent and ideally promote a multi-disciplinary approach involving a range of health and mental health professionals including counsellors and social workers (see Exhibit "A", at fn 13). There is no reason that these protocols should not continue to apply when a person makes a request for PAS/VE, precisely to determine which factors underlay the request. However, how these protocols are to be triggered and managed in the context of health care systems in response to requests for PAS/VE is not at all clear in current proposals by health profession associations responding to *Carter*. It will be essential that in order to protect autonomy in requests for PAS/VE, that the administration of these protocols strike the right balance between autonomy, dignity and the need to protect vulnerable persons. At the same time, the vulnerability assessment process needs to be sufficiently comprehensive to ensure persons are not vulnerable to being induced or coerced to commit suicide through sometimes subtle means that have been acknowledged to operate in the patient-physician relationship and decision-making process for PAS/VE as it operates in the Benelux countries (see Exhibit "A" at fn 25).

11. CACL also respects the Court's recognition that "strict limits that are scrupulously monitored and enforced" are justified to safeguard vulnerable persons from

"being induced to commit suicide in a time of weakness; taking their own lives; and abuse and error in the health care system".[2] The Court did not specify the safeguards for PAS/VE in its declaration of invalidity of the total ban, leaving it to Parliament to design the system, and stating that, "[c]omplex regulatory regimes are better created by Parliament than by the courts."[3] Thus, the Court provided wide scope for Parliament to design and implement safeguards within the parameters of a continued *Criminal Code* ban on PAS/VE where needed to protect vulnerable persons from being induced to commit suicide in times of weakness.

Why Additional Safeguards are Needed Beyond those in Place in Benelux Countries and Some Current Proposals for the Canadian Context

12. Current regimes in other jurisdictions and most proposals for a physician-assisted suicide and voluntary euthanasia (PAS/VE) system in Canada rely on the private patient-physician decision-making consent process to authorize access. Even where such systems provide entitlement to palliative care, they leave vulnerable persons inadequately protected, and moreover lead to "criterion creep", rapidly increasing numbers of PAS/VE deaths and increasingly permissive criteria for access to PAS/VE, as made clear in the affidavit by Professor Montero submitted in the *Carter* case by the Attorney General for Canada. This is further supported by the recent example in Belgium where a doctor may be facing criminal charges for providing "assistance" in the death of a senior (see the National Post article at Exhibit "B"). Rather than being caught by the monitoring system in place in Belgium, this instance only came to the attention of authorities because it was publicized on television. The monitoring process was not enough to protect the

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[2] *Carter*, at para 27.
[3] *Carter*, at para 125.

individual. Without more stringent checks and balances beyond having a second physician who consults on the request, especially in the Canadian context where we are far from having an entitlement to comprehensive palliative and home care programs in any way comparable to those in the Benelux countries, it will be impossible to be certain that people who meet the medical and suffering eligibility criteria are not vulnerable in other ways (see *Health Law in Canada* attached as Exhibit "C", at p. 7).

13. Evidence from other jurisdictions shows that some people will be motivated to request PAS/VE because of suffering caused or compounded by factors other than their medical condition, such as: the experience of disability itself; related social and economic disadvantage; victimization and domestic abuse; family and caregiver stress, inducement and coercion; social isolation and stigma; and barriers to health care access (see Exhibit "A", at fn 25). This provides further evidence that strong safeguards are required to account for other factors that may motivate a PAS/VE request.

14. Attending physicians are usually not trained, nor widely experienced in identifying such a wide range of factors or in recognizing the subtle and unconscious ways inducement can operate even in the health care decision making context. Consequently, factors which have a bearing on a person's suffering may go unknown or unrecognized by the attending physician(s).

15. Managing access to PAS/VE through the Benelux approach of informed consent with one or two physicians will leave people who are socially and economically disadvantaged extremely vulnerable to inappropriate and unjustified access resulting in

their death. Those in the community would be particularly vulnerable, because, unlike in the Benelux countries, Canada generally has underdeveloped community care services.

16. Factors causing or compounding a person's suffering will go unidentified and unaddressed by attending physician(s). In the absence of qualified professionals and a multi-disciplinary approach with advance independent review, the system will fail to adequately distinguish between:

- those persons requesting PAS/VE as a considered, voluntary and non-ambivalent decision because of the suffering directly caused by their medical condition; and
- those situations where a person's social and economic vulnerability in their home, community and in the health care system itself is leading, inducing or coercing them to request PAS/VE as a way to end their life.

17. Risk factors for suicidal ideation and intent are growing in Canadian society and will likely motivate an annual increase in requests each year, as seen in all other jurisdictions where PAS/VE has been introduced. Risk factors include increasing prevalence in Canada of major conditions of physical disability, intellectual disability and neurological conditions including multiple sclerosis, spinal cord and/or brain injury. When combined with other factors related to social isolation and marginalization, material deprivation, lack of needed palliative, individual and family support, and inadequate health care response to suicide risk, the resulting increased risk of suicidal ideation and intent will likely increase requests for PAS/VE. Without adequate safeguards and oversight, as would be the case by transplanting the Benelux system here, some of these requests would be mistakenly granted.

18. CACL is concerned that disability-related psychological suffering will become a primary motivation and justification for PAS/VE, thus contributing to disability stigma and a vicious cycle. Evidence from other jurisdictions indicates that disability-related reasons (e.g., fear of dependence on others, loss of function, self-shame of one's incapacities) motivate requests for PAS/VE and justify its authorization (see Exhibit "C", at p. 6). A vicious cycle can ensue. Enduring and intolerable psychological suffering comes to result from living with a disability in a society and culture where a person's physical, intellectual and psychological differences and dependencies are increasingly used to justify terminating life.

Benchmarks for Designing a Safeguards System that Builds Trust and Respect

19. If people with disabilities and Canadians more generally are to vest their trust in a system for PAS/VE then safeguards must include:

a) Measures that enable people to access PAS/VE on the terms provided by the Court;
b) Pan-Canadian standards for consistent, transparent and reliable checks and balances when responding to requests for PAS/VE, including mandatory vulnerability assessment and separation of the assessment of eligibility and decisional capacity from the authorization process;
c) *Criminal Code* protections for vulnerable persons;
d) Assurance that the system will be able to distinguish between those who truly do meet the Carter criteria, and those whose suffering is caused or compounded by other factors;
e) Proactive measures to respond to suicidal ideation and intent where the suffering is not caused directly by the medical condition and/or the consent is not valid;

f) Special attention in the consent, assessment and review process to reasons for requesting PAS/VE that are based on psychological suffering arising from disability-related stigma (e.g. self-shame, sense of burden, losing capacity), including duties to explore alternatives as part of the informed consent process in these cases;

g) Proactive public awareness and promotion of disability-positive stories, examples and images of persons with significant disabilities; and

h) Processes that actively engage people with disabilities and their representative organizations in the oversight of the system.

20. CACL has undertaken a number of initiatives to develop safeguards proposals to address the issues identified above and to show how these benchmarks can be achieved. As well, CACL has engaged legal experts to develop a legislative option consistent with *Carter.* Without a full Parliamentary hearing process, and parallel processes at provincial/territorial levels, these and other proposals will not have the opportunity to be fully considered (See Exhibit "A"; "Protecting Choice & Safeguarding Inclusion" attached as Exhibit "D").

CACL's Proposals Requiring Further Consideration

21. CACL's proposals include:

a) Clearly defining 'grievous and irremediable medical condition' to mean end-of-life patients in an advanced stage of irreversible decline in capability, as a way to limit the risk of vulnerable persons being induced to commit suicide in times of weakness.

b) Mandatory vulnerability assessments by a qualified professional other than the attending physician, for every person making the request for PAS/VE, designed as a stepped process: 1) screen for any vulnerability factors (if none, proceed to authorization; 2) if vulnerability factors exist: a multi-disciplinary team inquires into risks; 3) if the risk is too high: arrange alternative courses of action.

c) A statutory mechanism required under the *Criminal Code* to provide advance review and authorization by an independent body of all requests for PAS/VE and to provide checks and balances, and an expedited process where needed.

d) Annual reporting on requests, outcomes and vulnerability assessments to provincial/territorial legislatures and to Parliament.

e) Federal and provincial/territorial government joint investment strategy in palliative care and needed disability-related supports.

22. These proposals have been detailed in three documents:

1) A draft legislative proposal for amendments to the *Criminal Code,* commissioned by CCD and CACL and prepared by David Baker and Gilbert Sharpe (see Exhibit "C", at Appendix 1). This is the only comprehensive legislative proposal in Canada to respond to the issue of safeguards, and is the result of extensive research and consultation. The process began in June 2015 and the draft has been widely shared with the

Department of Justice, counsel involved in *Carter*, the Federal and Provincial-Territorial Panels and will be published in Health Law in Canada in February (attached as Exhibit "C"). This proposal has also been shared through webinars and public presentations. The focus of this proposal is on the mechanisms for advance independent review and authorization of all requests for PAS/VE, pointing to the Mental Disorder Review Boards under the *Criminal Code* as an example of the kinds of authorities legislated under the *Criminal Code* that could be used for this purpose. Mr. Sharpe is a health law lawyer who has drafted innumerable pieces of fundamental health legislation, including the mental disorder provisions found beginning at s.672.1 in the *Criminal Code.* Mr. Sharpe also played a major role in the federal-provincial consultations leading up to the implementation of those provisions.

i. CACL views such a mechanism as an essential safeguard to meet the legislative objective to protect vulnerable persons from being induced to commit suicide. Despite its wide distribution, the proposal has not been given consideration by elected Members of Parliament or of the provincial/territorial legislatures because any such processes are awaiting the reports and recommendations of the Federal and Provincial/Territorial panels, which have not yet been released.

2) *Protecting Choice and Safeguarding Inclusion: a proposal to regulate physician-assisted suicide and voluntary euthanasia in Canada,* issued by

CACL in September 2015 detailing the proposals listed above and their rationale (attached as Exhibit "D").

3) *A Proposed Framework for Vulnerability Assessment: to regulate access to physician-assisted suicide and voluntary euthanasia in Canada*, issued by CACL in December 2015 and outlining a framework for mandatory vulnerability assessment to safeguard persons vulnerable to being induced to commit suicide in times of weakness (attached as Exhibit "A").

23. CACL is of the view that additional time is required for Parliament and provincial/territorial legislatures to consider these and other proposals in light of the findings and recommendations still to be made public by the Federal External Panel and the Provincial-Territorial Expert Advisory Group. Without the opportunity to develop the strongest possible safeguards that fully respect autonomy and the right to access PAS/VE, a weak safeguards system will result by default – i.e. one managed primarily through the private patient-physician decision-making relationship with input possibly of a second physician. For reasons, outlined in this affidavit, we believe such an approach is woefully inadequate and entirely at odds with the very clear direction the Court gave in *Carter* for a complex regulatory response to a complex social policy issue, and justifying stringent safeguards to be strictly enforced.

24. CACL and CCD expressed concern in its factum in *Carter* about the hearing process at trial and in particular the incomplete evidence about the frailty of the safeguards in Benelux countries and the consequent deaths occurring. The Court's acceptance of Professor Montero's affidavit only partially redressed this deficiency.

While the Court concluded that things are very different in the Benelux countries and warned against drawing direct parallels, the fact that remains is the Court left unaltered the trial judge's finding that adequate safeguards are possible and with it the assumption that the Benelux model is sufficient.

25. The Court made clear it had no intention of prejudging the question of sufficiency of safeguards leaving that determination to Parliament. Unless Parliament has the time required to make an informed determination in the sufficiency of safeguards, then the intent of the Court is not being upheld. If this Court does not extend the suspension, CCD and CACL will be deprived of any realistic opportunity to address this issue with Parliament and its provincial-territorial partners. To be clear CCD and CACL make no claim on the Court that it should favour our proposal over any other. We rather request that the Court recognize that unless the suspension is granted, no one proposing any models that promote proper safeguard's will have the opportunity to make their case to Canada's elected representatives and the Court's balanced approach between safeguards for vulnerable people and the right of self-determination will be lost.

AFFRIMED IN TELEPHONE COMUNICATION
WITH ME at the City of Toronto,
On December 9, 2015

Commissioner for Taking Affidavits

Michael Bach
[Electronic signature affixed as directed]

INDEX OF EXHIBITS

EXHIBIT	DATE	TITLE
A	December, 2015	A Proposed Framework for Vulnerability Assessment: to regulate access to physician-assisted suicide and voluntary euthanasia in Canada
B	October 29, 2015	Belgian doctor facing possible murder charge for euthanizing senior seen as warning for Canada
C	Forthcoming February 2016	Federal and Provincial Responsibilities to Implement Physician Assisted Suicide (with Appendices) 1. Baker, David and Sharpe, Gilbert. Draft Federal Legislation to Amend the Criminal Code to be Consistent with *Carter v Canada (Attorney General)* 2015 SCC 5. (*An Act to amend the Criminal Code as it relates to Physician-Assisted Suicide and the Review board provisions)* 2. Tom Shakespeare, *Disability Rights and Wrongs* (Abingdon: Routledge, 2006) at 129 (Book of Authorities [BOA], Tab 5), as quoted in Exhibit "B": Opinion of Sheila McLean and Laura Williamson attached to Affidavit #1 of Sheila McLean filed November 7, 2011 at 51 (*Carter* JR, Vol. XLVII at 13411R). 3. Numbers, appended at Tab 3, sourced from Reasons for Judgment of the British Columbia Supreme Court dated June 15, 2012 at para. 400 (Carter JR, Vol. II at 230) [TJ Reasons] at paras. 475, 518; Steve Doughty, "Don't Make Our Mistake," Daily Mail, July 9, 2014 (Carter BOA, Tab 10).
D	September 2015	Protecting Choice & Safeguarding Inclusion: a proposal to regulate access to physician-assisted suicide and voluntary euthanasia in Canada

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This is Exhibit A referred to in the Affidavit of Michael Bach Affirmed before me this 9th day of December 2015

Commissioner for Taking Affidavits

A Commissioner, etc.

A Proposed Framework for Vulnerability Assessment

to regulate access to physician-assisted suicide and voluntary euthanasia in Canada

Issued by:
Canadian Association for Community Living
December 2015

50 years/ans
Canadian Association for Community Living
Association canadienne pour l'intégration communautaire

Contents

List of Tables

Introduction

A national dialogue is needed about what safeguards will protect vulnerable persons in a system for physician-assisted suicide and voluntary euthanasia (PAS/VE), now that the Supreme Court of Canada has struck down the universal prohibition of these interventions. In *Carter v. Canada*[1] the Court decided the *Criminal Code* ban must be lifted for cases where: 1) a consenting adult requests PAS/VE and has a grievous and irremediable medical condition that causes enduring suffering intolerable to that person; and 2) the person is not vulnerable to being induced to commit suicide in a time of weakness.

The Court stressed that a system to enable access to PAS/VE must strike a balance between protecting the right to autonomy and dignity of individuals who wish to choose PAS/VE, and protecting persons who are vulnerable to being induced to commit suicide. It determined that a safeguards system that imposed "stringent limits that are scrupulously monitored and enforced" would achieve this balance.[2]

CACL strongly believes that mandatory vulnerability assessments, independent review and advance authorization, and *Criminal Code* protection of the vulnerable are essential for this purpose. Without legislated requirements in the *Criminal Code* and clear process in this regard there will be no reliable standard for drawing a line around those considered too vulnerable to access this intervention. The consequences could be devastating for individuals, families and communities. As well, criminal liability could result for those involved in the assisted suicide or euthanasia of persons who were in fact vulnerable to being induced to commit suicide in a time of weakness, and for whose protection the Court has kept the *Criminal Code* ban against assisted suicide firmly in place.

This paper proposes a rationale and a framework for mandatory vulnerability assessment as part of that safeguards system. It responds to the question: ***How is the group of persons 'vulnerable to being induced to commit suicide in times of weakness' to be identified and protected in the context of requests for PAS/VE?*** Our proposals build on the framework issued by CACL in October 2015 and titled *Protecting Choice and Safeguarding Inclusion: A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada*[3] and draw from

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[1] Carter v. Canada (Attorney General), 2015 SCC 5.

[2] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 105, citing the earlier BC Supreme Court Decision.

[3] Canadian Association for Community Living (2015), Protecting Choice and Safeguarding Inclusion: A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada (Online: http://cacl.ca/sites/default/files/uploads/CACL%20-%20Choice%20and%20Inclusion%20-%20%20%28english%29.pdf).

proposals for a legislative amendment to the *Criminal Code* developed by David Baker and Gilbert Sharpe with respect to the need for advance independent review and authorization.[4]

This report is divided into six sections:

A. Use of Terms: Physician-Assisted Suicide and Voluntary Euthanasia (PAS/VE)
B. Understanding Vulnerability to Being Induced to Commit Suicide in a Time of Weakness
C. Growing Vulnerability in Canadian Society
D. Risk Management – Identifying and Safeguarding Vulnerable Individuals in PAS/VE
E. Modeling the Dynamics of Vulnerability to Being Induced to Commit Suicide in a Time of Weakness
F. Proposed Framework for Vulnerability Assessment

A. Distinguishing 'Physician-Assisted Suicide and Voluntary Euthanasia' from 'Physician-Assisted Dying'

Many policy analysts and commentators are now using the more general term of 'physician-assisted dying' to discuss policy options in response to *Carter.* Physician-assisted dying can encompass a wide range of palliative care interventions, many of which are currently available through the health care system, issues of access aside. For the purposes of law and policy reform we urge continued use of the original terms related to suicide and euthanasia. We do this not because we wish to be provocative or polarize discussion about this difficult topic. Rather, we want to be very clear about the interventions that need public policy dialogue and decision post the *Carter* decision especially in light of their unique legal context. A law and policy framework can provide ways of naming the interventions that may be more suitable in some cultural contexts, but in any implementation their unique nature in medical, social *and legal* terms requires terms of distinction.

1. Defining terms

What is now in question is how, and under what conditions, two specific interventions – physician-assisted suicide and voluntary euthanasia – will be legislated, regulated and delivered as part of physician-assisted dying in Canada. The difference between PAS/VE and physician-assisted dying has been succinctly distinguished by U.S. professor of psychiatry, Madelyn Hsiao-Rei Hicks:

> Physician-assisted suicide is when a doctor provides a patient a lethal overdose of medication for self-administration with the explicit goal of enabling the patient to commit suicide. It is ethically and legally distinct from prescribing medication with the express goal of pain relief

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[4] See David Baker and Gilbert Sharpe (2015), Draft Federal Legislation to Amend the Criminal Code to be Consistent with *Carter v. Canada (Attorney General)* 2015 SCC 5. Toronto: bakerlaw (Online: http://www.cacl.ca/sites/default/files/uploads/Baker-Sharpe%20An%20Act%20to%20Amend%20the%20Criminal%20Code%20(Physician%20Assisted%20Suicide).pdf).

> while understanding that death could occur earlier as a secondary effect (the double effect principle).[5]

In defining PAS/VE we are also guided by The Royal Society of Canada 'Expert Panel on End-of-Life Decision Making':

> "Assisted suicide" is the act of intentionally killing oneself with the assistance of another. "Voluntary Euthanasia" is an act undertaken by one person to kill another person whose life is no longer worth living to them in accordance with the wishes of that person.[6]

Because PAS/VE involve a decision to have oneself intentionally made dead, suicidal thoughts and intentions, or the wish to be dead, necessarily underlie the request for PAS/VE. This will be so even where the request is considered to be a rational, autonomously chosen act by the individual and a reasoned response to the condition of having a grievous and irremediable medical condition that causes enduring suffering intolerable to the individual. While the Canadian Psychiatric Association has not issued a practice guideline on assessment and response to suicidal intention, the American Psychiatric Association has, and it defines *suicidal ideation* as: "thoughts of serving as the agent of one's own death", and *suicidal intent* as "subjective expectation and desire for a self-destructive act to end in death."[7]

We believe the definitions provided by the Royal Society of Canada Expert Panel and the American Psychiatric Association are helpful guides in beginning to delineate the group who may be vulnerable to being induced to commit suicide in times of weakness, as distinct from the group who should, according to *Carter*, be found eligible for access to PAS/VE.

2. Distinct legal status of PAS/VE interventions

The legal status of PAS/VE requires particular attention in light of the Supreme Court of Canada's ruling that there are individuals who must be protected from accessing these interventions because they are at too great a risk of being induced to commit suicide in a time of weakness. A key question is whether PAS/VE is legally any different from other end-of-life treatment decisions like refusing life-sustaining treatment or requesting its termination. The Supreme Court of Canada reasoned in *Carter* that "logically speaking" those who refuse such treatment may be no less vulnerable than those who request PAS/VE:

> Concerns about decisional capacity and vulnerability arise in all end-of-life medical decision-making. Logically speaking, there is no reason to think that the injured, ill and disabled who

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[5] Madelyn Hsiao-Rei Hicks (2006), "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors," *BMC Family Practice* (7:39, online: http://www.biomedcentral.com/content/pdf/1471-2296-7-39.pdf).

[6] The Royal Society of Canada Expert Panel (November 2011). *End-of-Life Decision Making*. Ottawa: Royal Society of Canada, at p. 7.

[7] American Psychiatric Association (2010), *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviours* (online: http://psychiatryonline.org/pb/assets/raw/sitewide/practice guidelines/guidelines/suicide.pdf, p. 9).

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> have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying.[8]

Nonetheless, *Carter* also makes clear that PAS/VE is to be provided only within the parameters of a *Criminal Code* prohibition that it is intended to protect "vulnerable persons from being induced to commit suicide at a time of weakness." This means that some individuals may not be able to access to PAS/VE because of the extent of their vulnerability to being induced to commit suicide, even if they may be able to exercise their right to refuse treatment. This is because, unlike for PAS/VE, there are no express provisions under the *Criminal Code* regulating refusal or withdrawal of life-sustaining treatment. The right of patients to refuse or withdraw medical treatment even if it results in death has been recognized as a common law right to refuse treatment.[9] Treatment that proceeds against a person's consent may constitute battery, but it is a violation under *common* law, not *criminal* law.

It is this legal distinction between PAS/VE and refusal of life-sustaining treatment that justifies designing more robust safeguards than the safeguards now in place for withdrawing or refusing life-sustaining treatment. The Court did not specify the safeguards for PAS/VE in its Declaration of invalidity of the total ban, leaving it to Parliament to design the system, and stating that: "Complex regulatory regimes are better created by Parliament than by the courts."[10] This does not mean that additional safeguards are not justified in decisions for refusing or deciding to withdraw life-sustaining treatment. It is simply that the *Carter* decision does not address that issue.

B. Understanding 'Vulnerability to Being Induced to Commit Suicide in a Time of Weakness'

The *Carter* decision is based on an understanding that suicidal ideation and intent can be motivated by the suffering caused by a grievous and irremediable medical condition. The decision affirms that ultimately it is the individual's subjective assessment of the endurance and intolerability of the suffering caused by the medical condition that justifies authorizing a request for PAS/VE. However, in acknowledging that there may be some individuals who have grievous and irremediable medical conditions that can cause enduring and intolerable suffering, but who may nonetheless be induced to commit suicide in a time of weakness, the Court recognized that there are other factors associated with suicidal ideation and intent.

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[8] Carter v. Canada (Attorney General), 2015 SCC 5 at para 115.

[9] *Nancy B. v. Hotel-Dieu de Quebec (1992), 86 D.L.R. (4th) 385 (Que. S.C.); Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.).*

[10] *Carter v. Canada (Attorney General)*, 2015 SCC 5 at para 125.

1. Factors other than the medical condition which cause suffering associated with suicidal ideation and intent

Risk for suicidal ideation and intent is of growing concern to health care providers in Canada. The WHO has estimated that since 1950 the suicide rate among men age 15-24 has increased 268%.[11] The Canadian Institute for Health Information has estimated that many more individuals have been hospitalized in Canada due to suicide attempts – 23,000 in a one-year period.[12] In response to concerns about growing risk, the Ontario Hospital Association and the Canadian Patient Safety Institute have developed a comprehensive framework to encourage standardized assessment of risk within health care settings.[13]

The research on suicide prevention and response in the health care context point to a wide range of factors associated with suffering that can lead to suicidal ideation and intention. Based on its review of clinical research, for example, the American Psychiatric Association points to a number of factors that increase the risk of suicidal ideation and intent, including:

- age (65 and older)
- gender (male)
    - While being male is associated with suicidal ideation and intent in general, a recent case review of 100 people requesting PAS/VE through the Belgium system, and for whom 'psychological suffering' was the primary source of suffering motivating the request, 77% were women.[14]
- marital status (widowed, divorced, single)
- race, ethnicity and culture
- socio-economic deprivation and unemployment (for both men and women)
    - In the study of 100 persons in Belgium seeking PAS/VE, 73% of the subjects overall were considered "medically unfit for work" and living on either disability allowances or having taken early retirement.[15]
- sexual orientation

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[11] World Health Organization (2003), *Suicide rates (per 100,000) by country, year, and gender* (online: http://www.who.int/mental_health/prevention/suicide/suiciderates/en/).

[12] Canadian Institute for Health Information (2004), *National Trauma Registry Analytic Bulletin: Hospitalizations Due to Suicide Attempts and Self-Inflicted Injury in Canada, 2001-2002* (Toronto: Author).

[13] Ontario Hospital Association and Canadian Patient Safety Institute, *Suicide Risk Assessment Guide: A Resource for Health Care Organizations* (online: https://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf).

[14] Lieve Thienpont, Monica Verhofstadt, Tony Van Loon, Wim Distelmans, Kurt Audenaert and Peter P De Deyn (2015), Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study," *BMJ Open* (5, online: http://bmjopen.bmj.com/content/5/7/e007454.full).

[15] Lieve Thienpont, Monica Verhofstadt, Tony Van Loon, Wim Distelmans, Kurt Audenaert and Peter P De Deyn (2015), Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study," *BMJ Open* (5, online: http://bmjopen.bmj.com/content/5/7/e007454.full).

- major psychiatric syndrome
- specific psychiatric symptoms (anxiety, hopelessness)
- anxiety, eating and alcohol and substance abuse disorders
- physical and/or sexual abuse
- domestic violence
- family history of suicide

Other research indicates suicidal ideation and intent is also associated with:

- onset of physical disability[16]
- with the three major disability conditions of intellectual disability (when associated with other types of disability in persons with mild intellectual disability, people who would likely be able to consent to PAS/VE), spinal cord injury and multiple sclerosis.[17]

In its 2010 report on preventing suicide, the U.S. Joint Commission which accredits almost 21,000 health care facilities and programs in the U.S identifies an extensive list of risk factors for suicidal ideation, intent and behaviour health care providers identify through event reports:

> The risk factors common across health care settings include having previously attempted suicide; recent suicide attempt; suicidal thoughts or behaviors; a family history of suicide or psychiatric illness; on antidepressants; physical health problems, including central nervous system disorders such as traumatic brain injury; diagnosis of delirium or dementia; chronic pain or intense acute pain; poor prognosis or prospect of certain death; social stressors such as financial strain, unemployment or loss of financial independence; disability; trauma; divorce or other relationship problems; hopelessness; and substance abuse. Substance abuse may also exacerbate psychological symptoms such as depression, and the disinhibitory effects of alcohol may contribute to impulsive suicidal behavior. Older adults are prone to additional suicide risk factors including declining health, loneliness and recent bereavement.[18]

All of the factors identified above are associated to varying degrees, and always depending on circumstances, with inducing suicidal ideation and intent which can lead to suicidal behaviours. As discussed in section C below on 'Growing Vulnerability in Canadian Society,' a number of these factors are also related to conditions of lack of individual disability-related and family supports leaving people without the back up support they require to manage daily life when also dealing with meeting often extensive support needs.

Co-presence of the factors in any particular case – for example, physical disability, plus major psychiatric syndrome, plus domestic violence – increase the risk of inducing suicidal ideation

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[16] D Russell, RJ Turner and TE Joiner (2009), "Physical disability and suicidal ideation: a community-based study of risk/protective factors for suicidal thoughts," *Suicide and Life-threatening Behaviour* (V. 39 (4), p. 440-451).

[17] MJ Gianni, B Bermark, S Kreshover, E Elias, C Plummer and E O'Keefe (2010), "Understanding suicide and disability through three major disabling conditions: intellectual disability, spinal cord injury and multiple sclerosis," *Journal of Disability and Health* (3(2), p. 74-78).

[18] The Joint Commission (2010), "The Joint Commission sentinel event alert: A follow-up report on preventing suicide: Focus on medical/surgical units and the emergency department" (Issue 46, online: http://www.jointcommission.org/assets/1/18/SEA_46.pdf).

and intent. Even for patients who come into palliative care with a long history of disability, factors associated with their experience of prejudice, bias, disenfranchisement, and devaluation have been shown to increase their suffering and vulnerability in this context.[19]

Various health practice guidelines developed for both psychiatric practice and family medicine[20] and across an array of health providers[21] indicate increasingly sophisticated understanding of the factors and processes associated with inducing suicidal ideation and intent. The aim in many of these efforts is to develop a more standardized approach to effectively intervening to limit the risk of suicidal behaviour and death. The Ontario Hospital Association and Canadian Patient Institute integrate these factors in a conceptual framework of "warning signs" and "potentiating risk factors" to guide suicide risk assessment and response in a variety of health care settings (see **Table 1**).

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[19] D Stienstra and HM Chochinov (2006), "Vulnerability, Disability, and Palliative End-of-Life Care," *Journal of Palliative Care* (22, 3, Autumn).

[20] See, for example, American Psychiatric Association (2010), *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviours* (online: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf); and Michael Gliatto, K Anil and MD Rai, "Evaluation and Treatment of Patients with Suicidal Ideation," *American Family Physician* (59(6), p. 1500-1506.

[21] R Giordano JF Stichler (2009), "Improving Suicide Risk Assessment in the Emergency Department," *Journal of Emergency Nursing* (35:22-6); For a list and links to resources on suicide prevention and protocols see for example "Practical Tools" published by the British Columbia Ministry of Children and Family Development (online: https://www.mcf.gov.bc.ca/suicide_prevention/practical_tools.htm).

Table 1. Illustration of the Accumulation of Potentiating Risk Factors and Warning Signs on Risk of Suicide[22]

Very High Risk:
Seek immediate help from emergency or mental health professional.

WARNING SIGNS:

- Threatening to harm or end one's life
- Seeking or access to means: seeking pills, weapons, or other means
- Evidence or expression of a suicide plan
- Expressing (writing or talking) ideation about suicide, wish to die or death
- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless, engaging impulsively in risky behaviour
- Expressing feelings of being trapped with no way out
- Increasing or excessive substance use
- Withdrawing from family, friends, society
- Anxiety, agitation, abnormal sleep (too much or too little)
- Dramatic changes in mood
- Expresses no reason for living, no sense of purpose in life

High Risk:
seek help from mental health professional

POTENTIATING RISK FACTORS

- Unemployed or recent financial difficulties
- Divorced, separated, widowed
- Social Isolation
- Prior traumatic life events or abuse
- Previous suicide behaviour
- Chronic mental illness
- Chronic, debilitating physical illness

Low Risk:
recommend counseling and monitor

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[22] This table is presented in: Ontario Hospital Association and Canadian Patient Safety Institute, *Suicide Risk Assessment Guide: A Resource for Health Care Organizations* (online: https://www.oha.com/KnowledgeCentre/Documents/Final%20-%20Suicide%20Risk%20Assessment%20Guidebook.pdf). This table is adapted in that text from MD Rudd, AL Berman, TE Joiner, MK Nock, MM Silverman, M Mandrusiak, K Orden & T Witte (2006), "Warning signs for suicide: Theory, research, and clinical applications," *Suicide and Life Threatening Behaviour* (36, 255-62).

for
development
of warning
signs.

2. How coercion can operate in requests and authorizations for PAS/VE

Outside of factors which are correlated with suicidal ideation and intent and which may shape request for PAS/VE, there are also concerns about more direct coercion motivating such requests. These concerns have been well documented, for example by the British Geriatric Society.[23] A review of actual cases also demonstrates the validity of these concerns, including documentation of coercion in requests for PAS/VE in both Oregon and Netherlands (see **Table 2** for examples).

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[23] British Geriatrics Society(2004), "Assisted dying for the terminally ill Bill BGS response to the House of Lords" (Online: http://www.bgs.org.uk/Publications/Position%20Papers/psn_terminally_ill_bill.htm).

Table 2 – Cases of coercion in physician-assisted suicide and euthanasia[24]

Case 1, Oregon: An 85-year-old cancer patient with worsening dementia requests PAS but her psychiatrist believes that she is being pressured by family. Nevertheless, she is then approved for PAS by a psychologist and receives assisted suicide

Case 2, Oregon: Louise, who has a degenerative neurological disease, requests PAS. As her disease progresses, those in her network who support her suicide become increasingly anxious that she will become too mentally or physically incapacitated to act on her request. This includes her doctor, her mother, a friend who will be present at her suicide, and the Oregon Compassion in Dying PAS advocate who has arranged for a New York Times reporter to fly in and cover the suicide. Louise says she is almost ready but not quite. She wants a week to relax and be with her mother. On learning indirectly that her doctor thinks she will not be able to act if she waits, she appears startled. Her mother tells her, "It's OK to be afraid." She replies: "I'm not afraid. I just feel as if everyone is ganging up on me, pressuring me. I just want some time".

Case 3, The Netherlands: A wife who no longer wishes to care for her sick, elderly husband gives him a choice between euthanasia and admission to a nursing home. Afraid of being left to the mercy of strangers in an unfamiliar place, he chooses euthanasia. His doctor ends his life despite being aware that the request was coerced.

Case 4, The Netherlands: Cees requests euthanasia one month after being diagnosed with ALS (MND). As required, his request is assessed by the primary doctor who will carry out the euthanasia and by a consultant. During their assessments, both doctors allow Cees's apparently resentful wife to answer all the questions directed to him, even though his speech is still understandable and he can type on a computer. His ambivalence about euthanasia is expressed by repeatedly pushing the date back. It is also expressed by weeping in response to the doctor's pro forma question of whether Cees is sure he wants to go ahead with euthanasia. His wife quickly answers affirmatively for him and then tells the doctor to move away from Cees, saying it is better to let him cry alone. At no point does a doctor ask to talk with Cees alone before his euthanasia.

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[24] This Table is reproduced from Madelyn Hsiao-Rei Hicks (2006), "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors," *BMC Family Practice* (7:39, online: http://www.biomedcentral.com/ content/pdf/1471-2296-7-39.pdf).

The review also indicates that "[r]equests for PAS and doctors' decisions to assist suicide can be influenced by coercion and by unconscious motivations in doctors, patients and caregivers."[25]

The psychiatric literature points to ways in the psychological dynamics of "transference and countertransference" can operate coercively between patient and physician in the context of requesting, considering and approving a request for PAS/VE:

> Transference and countertransference feelings are normal and can occur in any doctor-patient relationship. When these feelings heighten around emotionally intense issues, they can exert coercive pressure on clinical decision-making with an obligatory quality that is difficult to resist. Recognition is complicated by the frequent involvement of unacceptable feelings and urges that both doctor and patient wish to deny. That specialized training is needed to systematically recognize transference-countertransference may underlie the finding that Dutch GPs are worse than Dutch psychiatrists at recognizing when transference or countertransference has affected a request for EAS [Euthanasia/Assisted Suicide]. A survey of Dutch psychiatrists found that transference and countertransference influenced doctor-patient decision-making in 25% of all EAS requests for which psychiatric consultation was sought. Transference and countertransference influenced 19% of cases in which the request for PAS or euthanasia was granted, despite the advice of the consultant.[26]

Documented examples of how transference and counter-transference, or unconscious motivations, which operate on part of both the physician and the patient in the request process for PAS/VE are presented in **Table 3**.

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[25] Madelyn Hsiao-Rei Hicks (2006), "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors," *BMC Family Practice* (7:39, online: http://www.biomedcentral.com/content/pdf/1471-2296-7-39.pdf).

[26] Madelyn Hsiao-Rei Hicks (2006), "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors," *BMC Family Practice* (7:39, online: http://www.biomedcentral.com/content/pdf/1471-2296-7-39.pdf).

Table 3 – Inducement and Coercion in Dynamics of Patient-Physician Interactions in Requests for PAS/VE[27]

Transference is when a patient relates to the doctor in a way that primarily replicates other important, usually parental, relationships. It frequently acts on an unconscious level to covertly affect the patient-doctor interaction. As a general example, patients may relate to the doctor as an omnipotent parental authority figure. Their communications and behaviour may express a wish for approval, a wish for comfort and restoration, fear of abandonment, or rage at perceived abandonment. In any suicidal patient, including the terminally ill, the request to die can be a plea for help or an attempt to be given a rea- son to live. A request for PAS can be an entreaty for the doctor to take the terminally ill patient's situation or despair more seriously, or a test of the doctor's true feelings about the patient's value now that he is nearing death. One patient's request for euthanasia was described as *"the patient's way of 'testing' the medical team...to make sure they would not be abandoned. Moreover, as the patient had a difficult relationship with their family – who had asked for euthanasia to be carried out – this request enabled the patient to hear that they still had a certain value in the eyes of the medical team"*.

Another example is that of Mr. C., a 72-year-old man with severe obstructive lung disease. This patient asked his doctor, "Can't you do something to just bring it to an end? ...Just put me out of my misery. It would save everyone a lot of trouble." His doctor replied rather awkwardly, "Even though you feel like a burden, I can't do that." Mr. C. asks, "Why not? You'd do it for your dog." His doctor answers, "Because you aren't a dog, Mr. C. You're my patient and I'm your doctor, and I'm trying to help you. And I'll keep trying to help you as long as I have to." Mr. C. took the doctor's hand in both of his and said, "Thank God. I thought everyone had given up on me".

Rene Diekstra, a pioneer of PAS in the Netherlands, described how some doctors coming before a committee that reviewed PAS cases were prematurely ready to provide PAS when feelings of helplessness about the patient's condition influenced them to overestimate the rationality or inevitability of the patient's suicide. Fear of inadequacy and of abandoning patients by denying the PAS request can be observed in... interviews with Oregon doctors. One doctor favorable to PAS said, *"...I think I would just feel really uncomfortable if I couldn't help"*. Whether or not a doctor chooses to provide PAS, the patient's request for

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[27] The information in this Table is reproduced from Madelyn Hsiao-Rei Hicks (2006), "Physician-assisted suicide: a review of the literature concerning practical and clinical implications for UK doctors," *BMC Family Practice* (7:39, online: http://www.biomedcentral.com/ content/pdf/1471-2296-7-39.pdf).

PAS can be perceived as a rejection or a condemnation of the doctor's inadequacy. As one doctor said, *"It's almost as if your treatments and attempts to make the patient comfortable have been a complete failure if they're going to ask for that"*. And another: *"I feel like there's something with physician assisted suicide, personally, where I see it as a rejection of care...some- how the patient is saying, 'Whatever you're doing isn't good enough. It's not meeting my needs."*

Some doctors feel deep disgust towards disease and can have a profound fear of death and the helplessness that accompanies illness. Dr. Lewis Thomas writes, in an unusually naked portrayal of these feelings, *"Death is shocking, dismaying, even terrifying...A dying patient is a kind of freak...an offense against nature itself"*. Some individuals become doctors as a way of dealing with their death anxiety. Doctors' fears of death and of other issues around PAS can contribute to their avoiding much- needed discussions with patients about their impending death, both in doctors who support and who reject PAS. An Oregon doctor said about a PAS request, *"I kind of dealt with the medical issues and I didn't square up with it...I avoided it"*. This reaction can lead to doctors giving PAS prescriptions to patients without adequate evaluation...

3. Distinguishing between underlying causes of the request for PAS/VE

The need for making the distinction between underlying reasoning and causes in the request for PAS/VE has been identified through an extensive and detailed review of requests for PAS/VE in the Belgian regime, as cited above. Lieve Thienpont, et al, indicate that in considering each request a "clear distinction" should be made

> between suicidality (in thoughts and behaviour), which is symptomatic of (and/or triggered by) a number of psychiatric disorders, and a well-considered euthanasia request, which includes a patient's statement that his or her suffering is entirely unbearable, and that available treatment and medical assistance has been found to be inadequate. Therefore, we wish to underline that each euthanasia request must be scrutinised as a request for effective and far-reaching treatment, and that any such request demands exploration of all implications and clarification of alternatives.[28]

Evidence by one of the expert witnesses at the BC Supreme Court trial level, and quoted by Smith J in her judgment, also spoke to the validity of this distinction between suffering caused by the condition and other factors that motivate the wish to die:

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[28] Lieve Thienpont, Monica Verhofstadt, Tony Van Loon, Wim Distelmans, Kurt Audenaert and Peter P De Deyn (2015), Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study," *BMJ Open* (5, online: http://bmjopen.bmj.com/content/5/7/e007454.full).

> Professor James Werth, a Professor and licensed psychologist specializing in end-of-life counselling, deposes that, although decisions to seek hastened death may be made in difficult, emotionally-laden circumstances, nevertheless the decision-making process can be sound, rational and well reasoned. His evidence is that suicide related to mental illness, substance use, impulsivity and other psychosocial factors is different from end-of-life decision making by grievously and irremediably ill individuals. He says that the distinction is now well established in the mainstream of psychotherapy and that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.[29]

Smith J accepted Professor Werth's evidence that "it is problematic to conflate decision-making by grievously and irremediably ill persons about the timing of their deaths, with decision-making about suicide by persons who are mentally ill, or whose thinking processes are affected by substance abuse, trauma or other such factors." [30] As well, Smith J accepted the evidence that "influence can be subtle and exercised at an unconscious level" and that "coercion and undue influence can be detected as part of a capacity assessment." She also noted that: "To be accurate and reliable, clinicians who perform such assessments would have to be aware of the risks of coercion and undue influence, of the possibility of subtle influence, and of the risks of unconscious biases regarding the quality of the lives of persons with disabilities or persons of advanced age." [31]

While such distinctions can be made in practice, the recognition that complex and sometimes very subtle and unconscious factors related to suicidal ideation, inducement and coercion can operate in making the request for PAS/VE, speaks to the need for a robust vulnerability and capacity assessment process. Health professionals, and likely multi-disciplinary teams in some cases, who have particular expertise in being able to understand the complex dynamics that may be at play in the request for PAS/VE will be required for this purpose.

4. Defining those at risk of being 'vulnerable to being induced to commit suicide in times of weakness'

Because a wide range of factors are associated with suicidal ideation and intent, and that coercion can operate even in the context of the patient-physician relationship, a safeguards system must determine whether the source of suicidal ideation and intent in any particular instance is:

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[29] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, at para 813.

[30] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, at para 814.

[31] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, at para 814.

a) the person's grievous and irremediable medical condition that causes enduring suffering intolerable to the person in the circumstances of his or her condition;
b) other situational factors in the person's life known to be associated with suicidal ideation and intent and which may underlie the experience of suffering in the circumstances; and/or
c) coercive practices on the part of family, caregivers or operative in the dimensions of the patient-physician relationship.

Those in Groups b) and c) are individuals whose suicide-inducing suffering and requests for PAS/VE are substantially caused by, or contributed to, by factors *other than* the grievous and irremediable medical condition which they may also present.

Based on research and analyses cited above we propose that for the purposes of regulating access to PAS/VE persons who are 'vulnerable to being induced to commit suicide in times of weakness' can be defined as those for whom:

- factors known to induce suicidal ideation and intent or coercion, other than the suffering associated with the presenting grievous and irremediable medical condition, are present either singly or in some combination; and
- there is reasonable cause to believe that, in the particular case at hand, these other factors substantially underlay or contribute to the suicidal ideation, intent and the request for PAS/VE, and/or the experience of suffering which give rise to them, and that either:
    - interventions to address the needs arising from these other factors would have a likely outcome of reducing the suicidal ideation and intent sufficient for the person to withdraw the request; or,
    - the presence of situational factors associated with the suicidal ideation and intent sufficiently impair the person's decisional capacity to render voluntary and informed consent invalid in the circumstances.

Ensuring that health practitioners and authorizing bodies have the assessment tools they require to help manage these distinctions is essential if vulnerable persons are to be protected against being induced to commit suicide.

C. Growing Vulnerability in Canadian Society

Factors known to be associated with suicidal ideation and intent, and possibly coercion in accessing PAS/VE, are becoming more widespread among the Canadian population, for example:[32]

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[32] The following discussion of vulnerability in Canadian society is drawn from CACL's earlier report, Canadian Association for Community Living (2015), *Protecting Choice and Safeguarding Inclusion: A Proposal to Regulate*

- ***Increasing prevalence and severity of disability, and multiple disadvantage*** – Almost 14% of the adult population in Canada has a disability and this prevalence rate is growing year by year. Women are over-represented in almost all age groups.[33] Among Aboriginal persons, the prevalence of disability is over 30%, with this higher rate due to significant environmental and trauma-related disabilities.[34] Overall there is an increasing prevalence of people with 'severe' or 'very severe' disabilities, currently estimated at 1.8 million adults in Canada.[35] This is a group particularly vulnerable to abuse, social exclusion, and stigma especially those multiply- disadvantaged by gender or ethno-racial-cultural status.
- ***Lack of access to disability-related supports*** – A growing gap in needed disability-related supports affects both people with disabilities and families. Statistics Canada reports that unmet need for support increases with severity of disability, with 49% of people with severe disabilities needing help or not receiving enough help. For people with disabilities not living alone, 80% rely on families for needed support. For those living alone, 56% rely on their families.[36] With the aging of the population this gap will grow substantially – because of increased disability prevalence and more limited capacity of aging family caregivers.
- ***Gap in palliative care*** – 70% of Canadians are not able to access palliative care, [37] which will become a growing issue as annual deaths increase from the current rate of 260,000 deaths per year to more than 425,000 per year by 2036.[38] Lack of access contributes to the stress that both patients and family caregivers face at end-of-life, which may contribute to suicidal ideation and intent or coercion, as discussed above.
- ***Increasing prevalence of mental health difficulties*** – A study for the Mental Health Commission of Canada estimates 20% of Canadians experience mental health difficulties annually, including mood disorders, anxiety disorders, schizophrenia, attention deficit/hyperactive disorders (ADHD), personality disorders, substance use disorders or dementia. It estimates that within a generation more than 8.9 million Canadians will be

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Physician-Assisted Suicide and Voluntary Euthanasia in Canada (Online: http://cacl.ca/sites/default/files/uploads/CACL%20-%20Choice%20and%20Inclusion%20-%20%20%28english%29.pdf).

[33] Statistics Canada, Social and Aboriginal Affairs Division (2013). Disability in Canada: Initial findings from the Canadian Survey on Disability: Fact Sheet. Ottawa: Statistics Canada.

[34] Douglas Durst (2006). Urban First Nations People with Disabilities Speak Out. *Journal of Aboriginal Health* (September 2006).

[35] For a comparison of 2001 and 2006 disability rates in these population groups, see Statistics Canada, *Participation and Activity Limitation Survey: Analytical Report* (Ottawa: Statistics Canada, 2007), online: http://www.statcan.gc.ca/pub/89-628-x/89-628-x2007002-eng.htm (last accessed: 24 September 2014).

[36] Rubab Arim (2015). A profile of persons with disabilities among Canadians aged 15 years or older, 2012. Ottawa: Statistics Canada.

[37] The Honourable Sharon Carstairs (2010). *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*. Ottawa: Senate of Canada, at p. 24.

[38] Quality End-of-Life Care Coalition of Canada (2010). Blueprint for Action: 2010 to 2020. Ottawa: Author, at p. 1.

living with a mental illness.[39] People with disabilities who experience rates of violent victimization much higher than the general population are also more likely to self-rate poor or fair health status, as well as sleep disorders and use of antidepressants or sedatives, at rates 50% to 90% higher than the general population.[40]

- ***Mental health disability and other disabilities co-related*** – Statistics Canada estimates there are over 1 million Canadians with mental health disabilities, which are defined for population surveys as a long-term condition that limits daily activities. Of this group, almost 92% also report having at least one other type of disability.[41]
- ***Poverty and labour force exclusion*** – Working-age adults with disabilities are about twice as likely to live in poverty as the general population (20.5% versus 11%). Almost 40% of Aboriginal persons with disabilities live in poverty. Persons with severe disabilities are multiply disadvantaged, with over 50% living in poverty. Employment rates are far lower for working age adults with disabilities (51.3%) than those without (75.1%). Among working age people with intellectual disabilities, labour force participation is only 30%.[42] As noted above, in a study of those requesting PAS/VE in Belgium because of psychological suffering, 73% had been found medically unfit to work.[43]
- Violence, abuse and insecurity44 – People with disabilities are twice as likely as non-disabled persons to be victims of violence. People with some form of cognitive or mental disability, including intellectual disability, are four times more likely to be victimized than those without. Women with disabilities are sexually assaulted at a

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[39] P. Smetanin, D. Stiff, C. Briante, C.E. Adair, S. Ahmad and M. Khan (2011). *The Life and Economic Impact of Major Mental Illnesses in Canada: 2011 to 2041*. Toronto: RiskAnalytica, on behalf of the Mental Health Commission of Canada.

[40] See Samuel Perrault (2009). Criminal victimization and health: A profile of victimization among persons with activity limitations and other health problems. Ottawa: Statistics Canada.

[41] Christine Bizier, Carley Marshall and Gail Fawcett (2014). *Mental health-related disabilities among Canadians aged 15 years and older, 2012.* Ottawa: Statistics Canada.

[42] Cameron Crawford (2013). Looking Into Poverty: Income Sources of Poor People with Disabilities in Canada. Toronto: IRIS - Institute for Research and Development on Inclusion and Society, 2013. Online: http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/demographic-profile/income-sources-of-poor-people-with-disabilities; Crawford, C. (2013 version). *Disabling Poverty & Enabling Citizenship: Understanding the Poverty and Exclusion of Canadians with Disabilities.* Winnipeg: Council of Canadians with Disabilities. Online: http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/demographic-profile/understanding-poverty-exclusion.

[43] Lieve Thienpont, Monica Verhofstadt, Tony Van Loon, Wim Distelmans, Kurt Audenaert and Peter P De Deyn (2015), Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study," *BMJ Open* (5, online: http://bmjopen.bmj.com/content/5/7/e007454.full).

[44] For statistics referenced in this section, see Samuel Perrault (2009), *Criminal victimization and health: A profile of victimization among persons with activity limitations and other health problems* (Ottawa: Statistics Canada).

rate at least twice that of the general population of women in Canada. Almost two thirds (65%) of violent crimes against persons with activity limitations were committed by someone who was known to the victim. Persons with disabilities are 2 to 3 times more likely to be victims of the most severe forms of spousal violence, including being sexually assaulted, beaten, struck or threatened with a weapon. It is estimated that 80% of psychiatric inpatients have been abused in their lifetimes.45 Moreover, people with disabilities who are victims of violence are less likely than other victims to be satisfied with the police response and with the ability of courts to deal with the incidents in a timely manner. With the rate of sexual abuse experienced by Aboriginal persons with disabilities at five times the general population,46 aboriginal persons with disabilities are particularly vulnerable.

- Barriers to preventive and acute health care – People with intellectual disabilities are three to four times more likely to die preventable deaths because of barriers to needed health care and other supports. 47

Add to these factors the rapid aging of the Canadian population. This will mean a growing proportion of people with disabilities in the decades ahead and an increasing incidence of financial and other forms of abuse against persons with disabilities including older persons:

- ***Rapid increase in cases of dementia*** – The almost half a million Canadians with dementia in 2008 will increase 2.3 times by 2038 to over 1,125,000 individuals, at which point there will be 250,000 new cases diagnosed each year.[48]
- ***High rates of depression among seniors*** – The Canadian Institute for Health Information reports that over 40% of seniors living in residential care in Canada have either been diagnosed with depression or show symptoms of depression.[49]
- ***Elder abuse*** – Estimates of elder abuse prevalence range from 4-10% of the population, with financial abuse being the leading form.[50]

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[45] National Clearing House on Family Violence (2004), "Violence Against Women with Disabilities." (Ottawa: Minister of Public Works and Government Services Canada).

[46] Larry Chartrand and Celeste McKay (2006), *A Review of Research on Criminal Victimization and First Nations, Métis and Inuit Peoples 1990-2001 (Ottawa: Department of Justice Canada).*

[47] See P. Heslop et al (2014), "The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study," *The Lancet*; 383: 9920, 889–895; and Stacey Atkinson, Joanne Lay, Su McAnelly, Malcolm Richardson (eds.) (2015), *Intellectual Disability in Health and Social Care* (New York: Routledge).

[48] P. Smetanin, P. Kobak, C. Briante, D. Stiff, G. Sherman, G. and S. Ahmad (2010), *Rising Tide: The Impact of Dementia in Canada 2008 to 2038* (Toronto: Alzheimer Society Canada).

[49] Canadian Institute for Health Information (2010). *Depression among Seniors in Residential Care: An Analysis in Brief*. Ottawa: Author.

[50] See, for example, E. Podnieks (2008), Elder abuse: the Canadian experience. *Journal of Elder Abuse and Neglect*, (20(2):126-50); Charmaine Spencer (1998), *Diminishing Returns: An Examination of Financial Abuse of Older Adults in British Columbia* (Vancouver: Gerontology Research Centre, Simon Fraser University).

D. Risk Management – Identifying and Safeguarding Vulnerable Individuals in PAS/VE

Recognizing this growing vulnerability to factors related to suicidal ideation and intent as well as coercion in PAS/VE, what should the process be for identifying and safeguarding vulnerable individuals at the point of managing requests and authorizing access to PAS/VE? From a public policy perspective, this question can be framed as one of "social risk management"[51] – how will society manage the risks associated with requests for PAS/VE from individuals who are in fact vulnerable to being induced to make this request in a time of weakness, as this group has been defined above?

In applying social risk management to vulnerable populations, it has been proposed that vulnerability be conceptualized as a "risk chain" including: "a) the *risk* or risky events, b) the options for managing risk, or the *risk responses,* and c) the *outcome* in terms of welfare loss."[52]

Applying the 'risk chain' to the question of how to manage the risks associated with requests for PAS/VE from those vulnerable to being induced to commit suicide in a time of weakness, leads to specific questions for analysis:

a) What is the risk or risky event in this case?
b) Given this risk, what are the options for responding to and managing the risk?
c) What is the socially and legally acceptable outcome of the response?

1. What is the risk or risky event in this case?

The risk can be stated as follows:

> *That people who meet the medical criteria and make a request for PAS/VE will die, when in fact they were likely to have made another choice if they had been aware of other options and these had been made available; or, as a result of the unaddressed suicidal factors inducing or coercing their request, they were unable to give valid consent.*

These are individuals who would have been in a time of weakness when making the request for PAS/VE because of the extent of factors in their situation known to induce suicidal ideation and intent, or because of coercion by others, including subtle and unconscious coercion operative in the patient-physician relationship. Moreover, the suicidal ideation and intent arising from these factors and the suffering they caused would likely have been ameliorated sufficiently

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[51] See Robert Holzman and Steen Jorgensen (February 2000), *Social Risk Management: a new conceptual framework for Social Protection and Beyond* (Washington: Social Protection Unit, The World Bank).

[52] See Jeffrey Alwang, Paul B. Siegel, and Steen L. Jorgensen (2001), *Vulnerability: A View from Different Disciplines* (Washington: Social Protection Unit, The World Bank).

enough to withdraw the request had the underlying factors or coercion been identified and alternative courses of action to address the person's needs been made available.

2. Given this risk, what are the options for responding to and managing the risk?

A safeguards system must be designed to effectively respond to these risks. Existing health practice guidelines for suicide prevention and response in psychiatric practice, family medicine provide some guidance, and include such steps as:

- Need for screening and "multiaxial" diagnosis and assessment of factors which may be inducing suicidal ideation and intent, including psychiatric conditions, and "psychosocial stressors which may be either acute or chronic… such as sudden unemployment, interpersonal loss, social isolation and dysfunctional relationships" and baseline and current levels of functioning "and the patient's view of and feelings about his or her functioning."[53]
- Determining extent of suicidal ideation and identifying associated factors.
- Determining extent of planning and reasoning process that links intention to the behavior (or in this case, the request for PAS/VE).
- Developing a treatment plan which may include medication, social support, and hospitalization as may be needed.

Options for responding to the risk as defined above, and in the context of accepted practice guidelines for assessing factors associated with suicidal ideation and intent, could include:

- Screening for vulnerability to factors associated with suicidal ideation and intention
- Determination of whether the presence of suicidal-associated factors render the person in a situation of weakness – which would mean in this context the patient requesting PAS/VE is unaware of or not able to access courses of action that would ameliorate the suffering associated with the request for PAS/VE.
- Determination of whether factors inducing suicidal ideation and intent are of such a nature so as to render the person unable to validly consent in the circumstances.
- Assessment of "Patient Reported Outcomes" or patient-oriented assessment – which focus on patient perceptions and satisfaction with health care, and any impact of health care events from the patient's perspective. A growing body of research is finding that patient perception of care is a predictor of patient quality of life. Health care researchers in HIV/AIDS treatment, for example, note that:

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[53] American Psychiatric Association (2010), *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviours* (online: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf, p. 23).

> There is mounting evidence that variations in perceived quality of health care among people with HIV/AIDS affect patient behavior, especially adherence to medication regimens and other physician recommendations, as well as health outcomes

- These assessments provide important feedback information for adjusting interventions especially for patients with complex needs. The research indicates that:

  > One significant advantage of patient-oriented assessment is the ability to gain perspectives on care that are not available from any other source. This assessment procedure sheds light on concerns that may not make it into care because of patients' sense of futility, embarrassment, or independence.[54]

3. What are the socially and legally acceptable outcomes or standards for response?

Social risk management requires defining the socially and legally acceptable minimum outcomes that should result from management of the risk. Defining the minimums in this case should be guided by the Supreme Court of Canada's decision to allow PAS/VE under the exceptional circumstances it provides for, and its requirement that persons who are at substantial risk of vulnerability to being induced to commit suicide in times of weakness be protected. Given these parameters, and the analysis provided above, we recommend the following minimum standards for a safeguards system:

1. All requests for PAS/VE are screened to determine if the person is at risk of being induced or coerced to make the request in a time of weakness, as that has been defined above, to determine the extent to which:
    a. factors known to induce suicidal ideation and intent, other than the grievous and irremediable medical condition and the suffering it causes, are present, either singly or in some combination; and
    b. there is reasonable cause to believe that, in the particular case at hand, these factors underlay or significantly contribute to the suicidal ideation, intent and the request for PAS/VE, and/or the experience of suffering which give rise to them, and that either:
        i. interventions to address the needs arising from these factors would have a likely outcome of reducing the suicidal ideation and intent sufficient for the person to withdraw the request; or,
        ii. the presence of factors associated with the suicidal ideation and intent impair the person's decisional capacity sufficient to render consent invalid in the circumstances.

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[54] Bruce Rapkin, Elisa Weiss, Rosy Chhabra, et al (2008), "Beyond satisfaction: Using the Dynamics of Care assessment to better understand patients' experiences in care," *Health and Quality of Life Outcomes* (6:20 March).

2. If, through the screening process, the person *is found not to be* vulnerable to being induced to commit suicide in a time of weakness, the process for approving the request for PAS/VE must proceed.
3. If, through the screening process, the person *is found to be* vulnerable as defined above, additional consideration must be given to determine if:
    a. the person is aware of and fully understands and appreciates alternative courses of action that could ameliorate the factors associated with the needs and suffering motivating the request, and is refusing those alternatives in an informed and voluntary manner;
    b. is not fully aware of alternative courses of action and requires additional information and time to consider those options; or
    c. is unable to give informed and voluntary consent to proceed with the request at the time.
4. For those individuals for whom it is determined that the risk is too high that the person may be being induced or coerced to commit suicide (because of the extent of suicidal-inducing factors *other than* the grievous and irremediable medical condition):
    a. interventions to reduce needs underlying the request for PAS/VE must be explored and arranged to the extent possible, with the consent of the person; and,
    b. where a person is found not to have the decisional capacity to act legally independently in the circumstances, the least restrictive, most autonomy enhancing options must be arranged.
5. There must be no conflicts of interest in the process of receiving requests for PAS/VE, considering whether medical decisional capacity criteria are met, and in undertaking assessment of vulnerability to being induced to commit suicide in times of weakness.

E. Modeling the Dynamics of Vulnerability to Being Induced to Commit Suicide in a Time of Weakness

Determining in any particular case that the risk that a person is in fact being induced to commit suicide in a time of weakness (as that is defined above) is too high to render consent to PAS/VE valid in the circumstances, requires an understanding the dynamics of vulnerability. This area of health and social research has grown substantially in the past few decades to arrive at an understanding of the multiple inborn or inherent factors combined with socio-economic, social status, environmental and community-related factors that make some individuals susceptible to risk of vulnerability on a temporary or persistent basis. The research suggests that individuals' capacities to cope with the risks associated with their vulnerability vary and depend upon factors such as "the availability or lack of intimate and instrumental support; and

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neighborhood and community resources that may facilitate or hinder personal coping and interpersonal relationships."[55]

More recent research has looked at developing models of vulnerability to determine how the variety of factors related to vulnerability intersect, as a basis for assessing vulnerability in the health care context – linking, for example, pre-disposing, enabling and need-related factors.[56] A recent synthesis of a wide body of research on vulnerability factors presents an understanding of the dynamics of vulnerability as a function of two intersecting dimensions – 'sources' of vulnerability and 'states' of vulnerability.[57] Applied to the question of vulnerability to the risk of being induced to commit suicide in a time of weakness, the framework would suggest the following:

- Sources of vulnerability would include:
    - Inherent vulnerability (e.g., to a grievous and irremediable condition)
    - Situational vulnerability (e.g., to a particular confluence of factors related to suicidal ideation and intention)
    - Pathogenic vulnerability (e.g. to dysfunctional, abusive, exploitative relationships)
- States of vulnerability
    - Dispositional (that the range of inherent, situational and pathogenic factors have some degree of potential to make one vulnerable to the risk of being induced to commit suicide in a time of weakness)
    - Occurrent (that the range of situational and pathogenic factors *are* making one vulnerable to the risk of being induced to commit suicide in times of weakness).

Table 4 applies the two dimensions of the state and sources of vulnerability to create a typology of the ways in which persons who have a grievous and irremediable medical condition and who are in a state of enduring and intolerable suffering, could also be vulnerable to being induced to commit suicide in a time of weakness as a result of other factors associated with suicidal ideation and intent.

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[55] David Mechanic and Jennifer Tanner (2007), "Vulnerable people, groups, and populations: societal view," Health Affairs (V. 26(5): 1220-1230 (Online: http://www.jenniferltanner.com/docs/HA_vulnerablegroupsetc_MechanicTanner.pdf). Also see, C Grabovschi, C Loignon and M Fortin (2013), "Mapping the concept of vulnerability related to health care disparities: a scoping review," *BMC Health Services Research* (V. 13, March, Published online: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3626765/).

[56] L Shi, GD Stevens, P Faed and J Tsai (2008), "Rethinking vulnerable populations in the United States: an introduction to a general model of vulnerability," *Harvard Health Policy Review* (V. 9(1):43–48).

[57] Catriona Mackenzie, Wendy Rogers and Susan Dodds (2014), "What Is Vulnerability, and Why Does It Matter for Moral Theory?" in Catriona Mackenzie, Wendy Rogers and Susan Dodds, eds., *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford: Oxford University Press).

Table 4 – Dynamics of Vulnerability to Inducement to Commit Suicide in Times of Weakness

States of vulnerability → Sources of vulnerability to being induced to commit suicide in times of weakness ↓	Dispositional (potentially vulnerable to being induced to commit suicide in times of weakness)	Occurrent (actually vulnerable to being induced to commit suicide in times of weakness)
Inherent (to the condition)	- When a person has a grievous and irremediable medical condition that causes enduring suffering that is intolerable in the circumstances, and	If the person's suicidal ideation results from: - The recent nature of onset of the medical condition (i.e. onset of disability through traumatic injury, a known factor in suicidal ideation and intent)
Situational (to a particular context)	- When a person has such a condition and experience; and - is also in a situation of social vulnerability (e.g. factors related to economic or social disadvantage), with unmet needs for medical, financial, psychological, social or caregiving support	If those unmet needs contribute to - the grievous and irremediable nature of the condition; and/or - making the suffering enduring or intolerable
Pathogenic (relates to dysfunctional or abusive interpersonal relationships or social status/standing)	- People with intellectual or cognitive/ neurological disabilities who are able to consent to life-ending treatments, are potentially vulnerable because of high risk of victimization and preventable death	- If caregivers are abusing, neglecting, exploiting or coercing - If facing discriminatory barriers to accessing needed health or social supports

F. Proposed Framework for Vulnerability Assessment

Based on the analysis and typology above, we propose a framework for vulnerability assessment with four main elements:

1. Positioning in Informed Consent Process
2. Structure of the Assessment Tool
3. Timing of Assessment process
4. Advance Independent Review and Authorization

Comprehensive tools for vulnerability assessment in the health care system have been developed. The approach presented here draws on the staged or 'stepped' approach designed by the British Medical Association in its "Safeguarding Vulnerable Adults – a Tool Kit for General Practitioners."[58] While this tool is not designed specifically for vulnerability assessment in the context of PAS/VE it is informed by concern for the types of vulnerability factors identified above.

1. Positioning in the Informed Consent Process

Vulnerability assessment would be positioned in the informed consent process as follows:

a. Patient makes request to responsible physician
b. Initial assessment of whether medical condition/suffering criteria are met, and decisional capacity to act legally independently – as per *Carter.*
c. If yes, responsible physician engages qualified professional to undertake assessment of vulnerability that could be decisionally-impactful – could be psychologist, social worker, other regulated professional designated for this purpose. This qualified professional is a separate health professional, thus helping protect against any criminal liability for proceeding with PAS when a person may have been vulnerable to being induced. It involves assessment of vulnerability factors, suicidal ideation and intent, patient-reported health care outcomes, and assessment of patient resiliency. It is designed to assess whether the consent is free, non-ambivalent and voluntary, and protects against any conflicts of interest in the health care system.

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[58] British Medical Association (2011), *Safeguarding Vulnerable Adults – A Tool Kit for General Practitioners* (London: Author, Online at: https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB0QFjAAahUKEwjS4v6_-urlAhUGpx4KHdPzAU4&url=http%3A%2F%2Fbma.org.uk%2F-%2Fmedia%2Ffiles%2Fpdfs%2Fpractical%2520advice%2520at%2520work%2Fethics%2Fsafeguardingvulnerableadults.pdf&usg=AFQjCNEVOS5NTs1Xmn_kAp7lb0idVbCdEw).

d. Decisionally-impactful vulnerability assessment is undertaken in a staged process (below).
e. If 'no risk' determined at stages 1 or 2, then physician completes the informed consent inquiry and proceed to advance independent authorization.
f. If too high risk determined at Stage 2, then request is denied at this point and qualified assessor works with patient to explore alternative courses of action including means to potentially reduce impactful vulnerability.

2. Structure of Vulnerability Assessment Protocol

We envisage a 3-stage assessment process:

Stage 1: Screening for Vulnerability and Assessing Patient-Reported Outcomes

Assessment takes place through a private and confidential interview with the individual alone (as required, for example, when donating blood). The assessment should be structured but undertaken in a respectful, sensitive, timely, dialogic manner.

a. Is the person at moderate, high or severe occurrent risk of factors inducing suicidal ideation and intent other than the grievous and irremediable medical condition (focus on nature of medical condition, expressed reasons for the request, psychological state, socio-economic status, social/interpersonal context, extent of unmet need for individual supports and caregiver support, relevant material circumstances)? No/Yes.
b. Does the person report health care events or outcomes indicating that health care provision itself has contributed to vulnerability and/or that changes to the health care regime, or addressing barriers identified, could affect perceived quality of life and the request for PAS/VE. This Patient Reported Outcome (PRO) assessment must be done by a qualified professional independent of the attending physician to ensure no conflicts of interest in the identification and assessment of the PRO.
    - A guide to assessing PROs in clinical settings drawing on an extensive set of assessment tools and research provides a helpful framework for assessment of patient assessments of health care events, symptom burden, functioning, health status, and health-related quality of life.[59]
    - Some PRO assessment tools look specifically at the impact of 'events' in the health care system over a period of time, and the "dynamics of care" which may have a cumulative impact on the patient's perception of quality of life, especially those with complex health needs.[60]

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[59] Neil Aaronson, Thomas Elliott, Joanne Greenhalgh, et al (2015), *User's Guide to Implementing Patient-Reported Outcomes Assessment in Clinical Practice* (International Society for Quality of Life Research, online: http://www.isoqol.org/UserFiles/2015UsersGuide-Version2.pdf).

[60] See, for example, Bruce Rapkin, Elisa Weiss, Rosy Chhabra, et al (2008), "Beyond satisfaction: Using the Dynamics of Care assessment to better understand patients' experiences in care," *Health and Quality of Life Outcomes* (6:20 March).

c. If response to a. and b. are 'No' then no further examination of vulnerability required. Qualified assessor makes report medical and decisional capacity criteria are confirmed, and that there are no significant warning signs that suicidal ideation and intent is due to other factors. Otherwise, proceed to Stage 2.

The degrees of vulnerability (moderate, high, severe) are adopted from a helpful "Vulnerability Assessment Tool" designed to address vulnerability of homeless persons to having their housing and other needs continuing to go unmet, and to being harmed by others.[61] It identifies ten domains of vulnerability, and has been both validity- and reliability- tested. While not designed for assessing vulnerability to being induced to commit suicide in times of weakness, it does assess some of the same factors the research identifies for vulnerability to suicidal ideation and intent. Moreover, it provides helpful scales of the degree of vulnerability in each of the domains it assesses, which could be adapted in designing assessment tools for the purposes outlined here.

Stage 2: Multi-disciplinary team Inquiry into risk and needs assessment – If 'Yes' to either a. or b. at Stage 1

a. A multi-disciplinary team undertakes examination of reasons and circumstances, extent of unmet support needs if presented, interpersonal and caregiving context, material deprivation, experience of discrimination/stigma/ indignity, exploration with the patient of whether alternative courses of action might be considered.
b. Team assesses whether person is able to act legally independently and is expected to be able to do so at the time of the administration of the PAS/VE.
c. Team makes determination made of whether the person is above the threshold of too high risk of being induced to commit suicide, and if the person requires decision-making supports of such an extent that they are unable to make the decision legally independently. No/Yes.
d. If No, then the decision-making process proceeds. No further examination of vulnerability required. Qualified assessor makes report on inquiry findings and finding of any material risk below threshold. If yes, proceed to Stage 3.

Stage 3: Safeguarding and Alternative Courses of Action

a. If yes at Stage 2 (that the risk to being induced is higher than acceptable threshold), then qualified assessor works with patient, multi-disciplinary team and relevant health

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[61] Downtown Emergency Service Center, "Vulnerability Assessment Tool for Determining Eligibility and Allocating Services and Housing for Homeless Adults" (Seattle, WA: Author, Online at: http://www.desc.org/documents/06.30.2015.DESC.Intro_to_Vulnerability_Assessment_Tool.incl%20VAT%20&%201-page%20validity.pdf).

and social service authorities/providers to explore and arrange alternative courses of action.

b. Protocols for responding to suicidal ideation and intent activated with a view to addressing vulnerability factors and building resiliency of the person to deal with situation.
c. Adult protection, legal capacity support, adult guardianship engaged as deemed necessary, where the adult lacks capacity to act legally independently.
d. Qualified assessor makes report on alternatives and arrangements, and recommends time-frame before a request for PAS can be considered.
e. Follow up by qualified professional, or designated authority, required.
f. All steps taken to maximize the capacity of the individual, and where the person is not able to act legally independently ensure access to needed decision-making supports.

3. Timing of Assessment Process

a. Stage 1 assessment must be done in a timely manner upon request by the physician. Determination should be rendered within 24 hours.
b. Stage 2 assessment must be undertaken within a reasonable time frame (to be determined), sensitive to the person's condition and context.

4. Advance Independent Review and Authorization

The United Nations Human Rights Committee has urged that in approving requests for PAS/VE independent review be provided for in order to "guarantee that this decision was not the subject of undue influence or misapprehension."[62] The Committee calls for "independent review by a judge or magistrate" because of the potential for violation of the "inherent right to life" as recognized in Article 6 of the International Covenant on Civil and Political Rights, ratified by Canada in 1976.

CACL proposes advance independent review and authorization of requests for PAS/VE along with an appropriate waiting period to ensure that the decision is, in fact, 'not the subject of undue influence or misapprehension.'[63] Detailed legislative proposals have also been developed in light of the *Carter* decision.[64] Decisions could be made in a very efficient manner,

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[62] U.N. Human Rights Committee, Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, para. 7, U.N. DOC. CCPR/C/NLD/CO/4 (Aug. 25, 2009). See also U.N. Human Rights Committee, Concluding Observations of the Human Rights Committee: Netherlands, para. 5–6, U.N. DOC. CCPR/CO/72/NET (Aug. 27, 2001).

[63] See Canadian Association for Community Living (2015), Protecting Choice and Safeguarding Inclusion: A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada (Online: http://cacl.ca/sites/default/files/uploads/CACL%20-%20Choice%20and%20Inclusion%20-%20%20%28english%29.pdf, pg. 16-19).

[64] See David Baker and Gilbert Sharpe (2015), Draft Federal Legislation to Amend the Criminal Code to be Consistent with *Carter v. Canada (Attorney General)* 2015 SCC 5. Toronto: bakerlaw (Online: http://www.cacl.ca/sites/default/files/uploads/Baker-Sharpe%20An%20Act%20to%20Amend%20the%20Criminal%20Code%20(Physician%20Assisted%20Suicide).pdf).

as experience with the Ontario 'Consent and Capacity Board' demonstrates. Provision should be made for expedited decision making as may be needed where a person may be close to death or the person's state of suffering requires urgent decision.

Submissions would be made to the independent body as follows:

a. Physician makes submission on medical criteria (as specified in the *Carter* decision) and decisional capacity.
b. Qualified professional provides results of vulnerability assessment (Stage 1, 2 or 3 assessment).

Conclusion

The Supreme Court of Canada decision in *Carter* upheld the ban on physician-assisted suicide and voluntary euthanasia for persons who may meet the medical and decisional criteria for access, but who are nonetheless 'vulnerable to being induced to commit suicide in times of weakness.' That the group at risk exists and is growing is without doubt. The Court recognized the importance and validity of the legislative objective to protect and safeguard this group in the strictest and most stringent manner. However, it left it up to Parliament to design the framework for identifying and safeguarding this group of individuals.

There is undoubtedly a conceptual and practical challenge in parsing out factors associated enduring and intolerable suffering that are related to a presenting medical condition, and those factors which are distinct but nonetheless have a determinative impact on a person's suffering or operate as a coercive force in motivating the request. However, these challenges are not insurmountable and indeed, seen from a social risk management perspective, they must be confronted with a sophisticated vulnerability assessment protocol and a multi-disciplinary approach. Combined with extensive research in recent years on factors associated with vulnerability, the modeling of the dynamics of vulnerability, and a growing body of vulnerability assessment tools, there are robust sources to be drawn upon in designing a framework and process for vulnerability assessment in access to PAS/VE.

A reliable system of checks and balances to assure consistent application of vulnerability assessment is essential. Without such attention, there is very real risk that people will die in a manner that violates criminal prohibition. This includes people who may appear to meet the criteria for PAS/VE but whose suffering is, in fact, substantially related to other factors that induce suicidal ideation and intent and which may underlie a person's experience of enduring and intolerable suffering. It also includes people who because of other factors in their lives, or in the dynamics of the relationship with their physician, are actually victims of subtle, unconscious or explicit coercion in the request for PAS/VE. Such outcomes would not only be an ethical and moral failure of health care and justice systems of immense proportions. Under *Carter,* it would also be criminal violation.

In order to protect against such risks, we have proposed a staged system of mandatory vulnerability assessment. Our proposals are sensitive to the Supreme Court's imperative that any safeguard system must balance the competing values of protecting the autonomy and dignity of a person's right to choose on the one hand, and the need to protect vulnerable persons on the other. To do anything less would be to prioritize the value of autonomy over protecting the vulnerable, and the Supreme Court provided no such avenue in its decision. Given the very real risk to vulnerable persons that could result from a system for physician-assisted suicide and voluntary euthanasia, it is of the utmost urgency and import to develop robust, transparent and consistent safeguards in which Canadians can build trust.

This is Exhibit B referred to in the Affidavit of Michael Bach Affirmed before me this 7th day of December 2015.

Commissioner for Taking Affidavits

A Commissioner, etc.

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Belgian doctor facing possible murder charge for euthanizing senior seen as warning for Canada

National Post, Graeme Hamilton | October 29, 2015 6:28 PM ET
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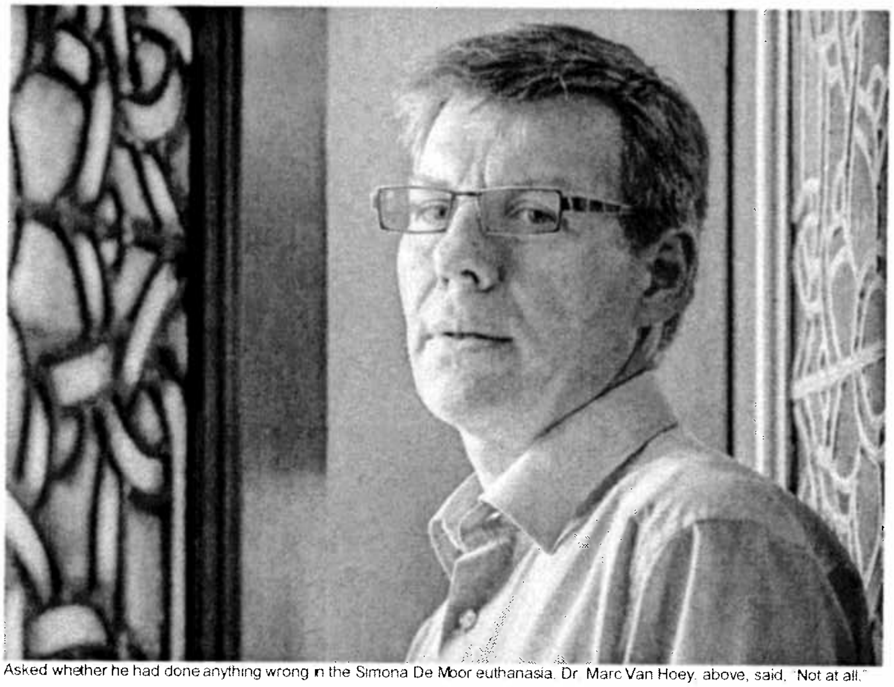


Asked whether he had done anything wrong in the Simona De Moor euthanasia, Dr. Marc Van Hoey, above, said, "Not at all."

Geert Vanden Wijngaert for National Post/Files

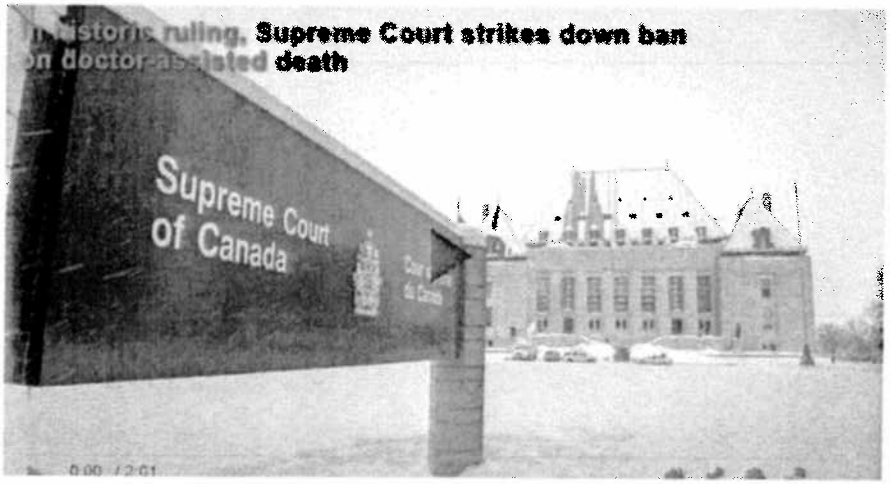
Simona De Moor was a fit 85-year-old who began each day at her Antwerp seniors home eating breakfast with friends and exercising on a stationary bicycle.

But after her beloved daughter died this year, the grief was unbearable and she immediately decided she wanted to take advantage of Belgium's euthanasia law. Three months later, as an Australian documentary crew filmed, Dr. Marc Van Hoey gave her a glass of lethal syrup to drink. Within five minutes she was dead.

With news Thursday that Van Hoey has become the first physician to face possible criminal prosecution for violating Belgium's 13-year-old euthanasia law, the De Moor case is being held up to Canada as an example of the dangers of legalizing physician-assisted death.

"I think it is very important to say that once you open the door and you think you are going to control euthanasia or assisted suicide, it's an illusion," said Carine Brochier, project manager of the Brussels-based European Institute for Bioethics. "It's an illusion to believe you can control what goes on between a doctor and a patient in a room."

Quebec's law legalizing euthanasia, modelled in part on the Belgian legislation, comes into force in December. Federally, the Supreme Court of Canada has given Parliament until February to draft legislation allowing physician-assisted death for consenting adults who suffer from a "grievous and irremediable" condition that causes intolerable physical or mental suffering. In Belgium, similar wording in the law has led to the euthanasia of people suffering from severe depression.



Brochier dismissed the argument that Canada would have more success controlling euthanasia because its medical culture is different from Belgium's.

"The culture can change. Here, 13 years ago, euthanasia was the exception," she said. "Now, the numbers continue to increase. It is no longer controlled. People say that euthanasia is the best way to die. The media say, look, he is having a glass of champagne with his children, and then the doctor arrives and kills him. It is the trivialization that is very dangerous."

Van Hoey confirmed to the National Post Thursday that his case has been "passed onto justice. ... I am advised not to give any comments at all," he said by phone. "I have to wait and be confident in what justice will do." Asked whether he had done anything wrong in the De Moor euthanasia, he said, "Not at all."

Van Hoey is president of Belgium's Flemish death with dignity association and one of the country's most active practitioners of euthanasia, performing between 15 and 20 per year.

In a 2013 interview, he told the National Post that Belgium had seen a shift toward euthanasia of the very old. He described approving the euthanasia of a 95-year-old woman who had lost all her friends and had given up on living. "Maybe if you say to that kind of person, 'We are not going to give you euthanasia,' they open the window on the fourth floor and jump down. And that's traumatic for everyone," he said.

He was frank about the flexibility of Belgium's euthanasia law, saying it was possible to skirt the requirement for a written request from the patient. He also acknowledged having helped a 56-year-old stroke victim who had been refused euthanasia obtain drugs to commit suicide.

Belgium's 16-member Federal Commission of Control and Evaluation was created to guard against any abuses of the euthanasia law, although it only analyzes cases after the patient has died. Critics say the commission's membership is heavily stacked with euthanasia advocates who have stretched the acceptable criteria. It had reviewed close to 10,000 deaths before identifying one — De Moor's — as suspicious.

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To be eligible for legal euthanasia in Belgium, a patient must suffer from a serious and incurable accidental or pathological condition, be in a hopeless medical condition and suffer constant and unbearable physical or mental pain that cannot be relieved.

A second medical opinion is required, and when death is not imminent, a specialist or psychiatrist is also supposed to be consulted. In the documentary broadcast last month, Van Hoey said he did not need to consult a psychiatrist about De Moor because of his own expertise.

“It’s not, she wants to die because she’s depressed,” he said. “She wants to die because she’s had it. See the difference?”

Jacqueline Herremans, president of Belgium’s French death with dignity association and a member of the control commission, said the meeting this week to discuss the Van Hoey case was “emotional” and “tense.” The decision was not taken lightly because it means Van Hoey could face a murder charge.

“It’s a serious act to refer a case to the courts,” she said.

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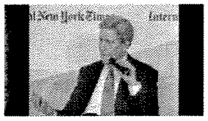

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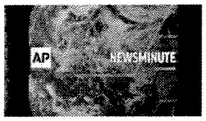

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This is Exhibit C referred to in the Affidavit of Michael Bach Affirmed before me this 5th day of December 2015

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David Baker and Rebeka Lauks, "FEDERAL AND PROVINCIAL RESPONSIBILITIES TO IMPLEMENT PHYSICIAN ASSISTED SUICIDE", November 17, 2015 [Forthcoming Health Law in Canada, February 2016]

The legality of physician-assisted suicide ("PAS") has finally been resolved by the Supreme Court of Canada ("the Court") in *Carter v Canada (Attorney General),* 2015 SCC 5 ("*Carter*").

The Court determined that it is not a crime for a qualified physician to assist a competent adult to commit suicide provided the person affected clearly consents to the termination of life, the person has a grievous and irremediable medical condition, and that condition causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[1]

The Court reversed its previous decision in *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519 ("*Rodriguez*"), because it determined that it would be possible for *Parliament* to develop safeguards adequate to protect people who are vulnerable.[2] In other words, although the Court provided the above-noted general criteria for establishing eligibility, it expressly left to Parliament how best to protect people who are vulnerable through establishment of effective safeguards.[3]

Colombia is the only other jurisdiction, apart from Canada, where a country's highest court legalized PAS.[4] Sixteen years later, in December 2014, that same Court recognized a countervailing right of persons with disabilities to support services and suicide prevention intervention with the coincident rights resolved through a regime requiring prior authorization by a review board before a physician is entitled to assist a person to commit suicide.[5]

THE NEED FOR A COMPLEX FEDERAL AND PROVINCIAL LEGISLATIVE SCHEME

While the Court did not specify whether this would be legislated at the provincial or federal level, it necessarily has to be addressed at both levels due to the amendments needed in the Criminal Code and due to health regulation falling under provincial power.

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[1] *Carter v Canada (Attorney General),* 2015 SCC 5, at paras 4 and 127 ["*Carter*"].

[2] *Ibid.*, at para 117.

[3] *Ibid.*, at para 126.

[4] Corte Constitucional de la República de Colombia. Sentencia C-239/97. Homicidio Por Piedad-Elementos/Homicideo Pietistico O Eutanasico/Homicidio Eugenisico. Bogotá DC. Cort Constitucional de la República de Colombia; 1997. Available online at <http://www.dmd.org.co/pdf/sentencia-c-239.pdf>.

[5] Corte Constitucional de la República de Colombia Sentencia T-970/14. Referencia: Expediente T-4.067.849. Acción de tutela instaurada por Julia [1] en contra de Coomeva E.P.S. Bogotá DC. Corte Constitucional de Colombia; 2014. Available online at <http://www.corteconstitucional.gov.co/relatoria/2014/t-970-14.htm>; In 2015, Colombia put into place a set of guidelines for PAS. Ministerio de Salud Y Proteccion Social de Colombia, "Lineamientos Sugeridos Para Hacer Efectivo el Derecho A Morir Con Dignidad en el Enfermo en Fase Terminal" (April 2015). Available online at <http://www.achc.org.co/documentos/prensa/Lineamientos%20derecho%20a%20morir%20dignamente.pdf>.

These shared responsibilities are constitutionally analogous to the Mental Disorder amendments made to the Criminal Code starting at section 672.1.[6] Through these amendments, Parliament enacted a "carve out" procedure for persons who could not be held criminally responsible due to mental disorder, allowing the provisions to stand for those who could. These amendments also clarified the need for federal-provincial collaboration pursuant to this legislative scheme, primarily through the creation of provincial/territorial Review Boards tasked with determining who meets the criteria for this "carve out". This is the only review board that exists in every province and territory.

The constitutionality of this federal-provincial legislative scheme has since stood the test of time.

The appended bill is proposed federal legislation which would similarly enact a "carve out" procedure for persons who engage in PAS according to the legislated criteria.[7]

There are those who feel there is no need for legislation whatsoever, or at most, a system for PAS similar to those employed in the Benelux countries. It is important to note, however, that the Court did not endorse the model used in the Benelux countries. In fact, the Court expressly referred to them as "permissive regimes" with "different medico-legal cultures."[8]

The Court went on to refer to what was needed for PAS as a "complex regulatory regime",[9] and expressly stated "Parliament must be given the opportunity to craft an appropriate remedy."[10]

The Court made these comments in finding that constitutional exemptions would not be an appropriate remedy in the case of PAS as it would create a system of uncertainty.[11]

It is for this same concern of uncertainty that a purely provincially-enacted scheme based on the Benelux model would not be desirable.[12] Unilateral provincial action would produce a wide variation in standards for PAS across the provinces, and the inevitable possibility of conflicts between the federal carve out and the provincial authorization.

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[6] *An Act to amend the Criminal Code (mental disorder) and to amend the National Defence Act and the Young Offenders Act in consequence thereof*, S.C. 1991, c. 43. Most of Bill C-30 was proclaimed in force in February 1992.

[7] Baker, David and Sharpe, Gilbert. Draft Federal Legislation to Amend the Criminal Code to be Consistent with *Carter v Canada (Attorney General)* 2015 SCC 5. (*An Act to amend the Criminal Code as it relates to Physician-Assisted Suicide and the Review board provisions).* ["Draft Federal Legislation"]. **Appended at Tab 1**.

[8] *Carter, supra* note 1 at paras 112-113.

[9] *Ibid.*, at para 125.

[10] *Ibid.*, at para 126.

[11] *Ibid.*, at para 125.

[12] An example of a purely provincially-enacted scheme based on the Benelux model would be Quebec's Bill 52, *An Act Respecting End-of-life Care*, 1st Reading, June 12, 2013, 1st Sess., 40th Leg., Quebec, 2013.

Without a "complex regulatory scheme", there is the risk of a wide variation across physicians practicing PAS as well, with vulnerable patients engaging in 'doctor shopping' which would be incompatible with the need for clear criteria and consistent application. The rule of law requires more than a physician acting based on his or her personal philosophy.

There is clear need for a national standard, but there is still an important role for the provinces to play. The provinces would still be tasked with determining options for palliative care and home care, physician remuneration, and assembling a group of 'vulnerability counsellors' and 'Assisting Physicians', all of which will be further addressed below.[13] Furthermore, under the appended scheme, it would be left to the provinces to decide on regulating the means of causing death.

Importantly, drawing from the "Not Criminally Responsible" provisions, the appended proposed federal legislation would leave to the provinces the role of determining who meets the criteria outlined in the proposed federal legislation through the use of provincially appointed Review Boards already established under the Criminal Code.

SAFEGUARDS TO ENSURE CRITERIA IS MET AND VULNERABLE PERSONS ARE PROTECTED

Vulnerability

The Court noted that the clear and proper object of the Criminal Code s. 241 prohibition is "to protect vulnerable persons from being induced to commit suicide in times of weakness"[14] but left to Parliament how best to achieve this objective through establishment of effective safeguards.[15]

In a way, anyone contemplating suicide can be said to be vulnerable, and therefore it cannot be an absolute prohibition to accessing PAS. Moreover, vulnerability cannot be said to be categorical. PAS is not to be denied because a person is poor, a member of a visible minority or a person with a disability. Rather vulnerability is contextual; a fact recognized by many witnesses in the *Carter* case, including Tom Shakespeare, a UK disability activist whose evidence was critical to the applicants' case on this issue. Shakespeare recognized that many, perhaps most, persons upon becoming disabled contemplate suicide, this intention passes when they have come to grips with their disability. Where a person is subject to exploitation or abuse, or simply tired of living, from which they can see no other means of escape, Shakespeare sees the need for the applications of safeguards. He noted the indisputable connection between the availability of palliative care and supports, such as home care, on the will of a disabled person to live. He was concerned that disability, in conjunction with suicidal ideation based on factors shared with the non-disabled, should not be recognized as meeting

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[13] Draft Federal Legislation, *supra* note 7 at s.241.1(6), s.241.1(13), and s.241.1(11).

[14] *Carter, supra* note 1 at paras 74, 86 and 90.

[15] *Carter, supra* note 1 at para 125.

the criteria for PAS. Shakespeare clearly connected the issue of vulnerability and need for effective safeguards.[16]

Based on this crucial evidence, the Court was able to approve the trial judge's finding that "the risks of physician-assisted death can be identified and very substantially minimized through a carefully-designed system that imposes strict limits that are scrupulously monitored and enforced."

The Court, recognizing it lacked the policy expertise and capacity to adequately address just what these safeguards would be, left it to Parliament to determine.[17]

The appended legislation sets out a comprehensive system of safeguards which are not only intended to identify whether a person meets the criteria, but also to protect persons while or if they are vulnerable. They do so through a process that would enable the person to make his or her choice after the source of their vulnerability has been addressed to the extent possible, or after a temporary period of vulnerability has passed.

Terminology

The Court was also clear it is not its job to develop policy, and therefore used broad language in establishing criteria, leaving the job of developing language capable of consistent application to Parliament.

It is unlikely the term 'grievously and irremediably ill' was intended to capture, for example, all blind people, yet the vagueness of the term leaves it open to interpretation that all blind people are grievously and irremediably ill. Moreover, how is one to distinguish enduring psychological suffering from simply being tired of living? In the real world, how difficult will it be to say when psychological suffering is caused by disability or by a host of co-existing disappointments which would equally lead non-disabled people to contemplate suicide?

These words require statutory definition capable of consistent application. As such, the appended legislation seeks to define the terminology set out in the *Carter* criteria to ensure that PAS will not become a widely-used and abused substitute to committing suicide.

In defining the terminology, the proposed bill makes a distinction between a medical condition and disease on the one hand and disability on the other, excluding the majority of persons with disabilities whose inclusion would be an abuse of the system.[18]

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[16] Tom Shakespeare, *Disability Rights and Wrongs* (Abingdon: Routledge, 2006) at 129 (Book of Authorities [BOA], Tab 5), as quoted in Exhibit "B": Opinion of Sheila McLean and Laura Williamson attached to Affidavit #1 of Sheila McLean filed November 7, 2011 at 51 (*Carter* JR, Vol. XLVII at 13411R). **Appended at Tab 2.**

[17] *Carter, supra* note 1 at para 125.

[18] Draft Federal Legislation, *supra* note 7 at s.241.1(1).

The draft bill also inserts a reasonableness standard into the definition for 'grievous', ensures that there is causation between the condition and the suffering,[19] and inserts language on terminology/imminence which,[20] although not a factor that would preclude a person from accessing PAS, is a question that should be looked at in determining the vulnerability of the person requesting PAS.

It is important to remember that those arguing in support of the case consistently stated that what they were asking for was for a limited group of people. Thus while a limit to those who are terminally ill with no more than 6 months to live, as is the case in the American states where PAS has been legalized may be too narrow,[21] it is reasonable to look at the language in s. 26(5) of Quebec's Bill 52 "in an advanced stage of irreversible decline" and consider whether some degree of terminality is not contemplated by the word "grievous".[22]

The Role of Physicians

The legislation sets out clearly that physicians would not be tasked with making the final decision, one way or the other, as to who can and cannot access PAS. Rather, they are left to do what they always do. The role of the "Responsible Physician" is to prepare a clinical evaluation of whether a "Patient" suffers from a disease or condition that is grievous and irremediable, identify the Patient's prognosis, and determine whether this condition is the cause of the intolerable suffering leading the Patient's request for PAS.[23]

The Responsible Physician also ensures that the Patient is fully informed of and has every opportunity to access medically necessary treatment, including appropriate palliative care, and alternate services, such as home care, that could alleviate the Patient's suffering and avoid the loss of personal dignity.[24]

The Responsible Physician would be the physician who knows the Patient best, whether it is his or her family doctor, or an attending physician.[25] This Physician would have no ethical basis for opting out of the process, as the role is just to provide information, not decide who is to live and who is to die.

The Responsible Physician would then refer the Patient to a "Consulting Physician", who would be a specialist in the cause/source of suffering leading to the request for PAS (e.g. palliative care specialist, oncologist, psychologist, neurologist, etc.).[26]

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[19] *Ibid*, at s.241.1(1), "Grievous".
[20] *Ibid*, at s.241.1(1), "Irremediable", and s.241(4)(f).
[21] Oregon Death with Dignity Act [ODDA] s. 1.01(12) (BOA, Tab 17).
[22] Bill 52, *An Act Respecting End-of-life Care*, 1st Reading, June 12, 2013, 1st Sess., 40th Leg., Quebec, 2013.
[23] Draft Federal Legislation, *supra* note 7 at s. 241.1(4)(a) and s.241.1(4)(b)(1).
[24] *Ibid*, at s.241.1(4)(b).
[25] *Ibid*, at s.241.1(1) "Responsible Physician".
[26] *Ibid*, at s.241.1(4)(c) and s.241.1(5).

In filling out the necessary documentation, both the Responsible and Consulting Physicians would make a determination of competence to consent, as well as potential sources of coercion and undue influence.[27] They would also evaluate the reasons given for the request for PAS, including an identification of factors not directly based on a Patient's illness or condition potentially causing or contributing to the intolerable suffering, such as social factors (i.e. self-worth weakened by exclusion, loss of independence, and discrimination) or economic factors (i.e. poverty).[28]

Vulnerability Counselling

In the comparator jurisdictions reviewed by the Trial Judge in *Carter,* the only record of reasons provided directly from those who sought PAS as to why they chose to do so comes from Oregon Health Services records. Notably, only 15.4% of those who sought PAS listed inadequate pain control or concern about it as a factor in their decision to seek PAS. The other reasons were identified as: losing autonomy (93.8% of those who sought PAS listed this as a reason); less able to engage in activities making life enjoyable (93.8%); loss of dignity (78.5%); losing control of bodily functions (46.2%); burden on family, friends/caregivers (26.2%); and financial implications of treatment (1.5%).[29]

Under the proposed legislation, if the Responsible and/or Consulting Physicians are of the opinion that the Patient may be suffering from a disorder or depression causing impaired judgement, or that the Patient may be vulnerable and would benefit from support in coming to terms with the real or apprehended consequences of their condition, and support in accessing medically necessary treatment or alternative services, then the physician is to refer the Patient for counselling.[30] This will be important in many cases, as a physician is not necessarily in the best position to know about home care, family life, or other circumstances in a Patients' life that may be impacting his or her decision, nor do physicians necessarily have the time or means of accessing the means of addressing vulnerability issues such as abuse.

Vulnerability counselling as proposed in the draft bill would require that, if palliative care were desired by the Patient, every palliative option be explored and exhausted.[31] The Counsellor's report to Review Board would document any gaps in service.[32] If the Review Board learns that a person is requesting PAS for lack of access to appropriate palliative care, it may then decide to direct that further efforts be made to provide such access before a request for PAS is granted.

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[27] *Ibid,* at s.241.1(4)(a), s.241.1(4)(c), s.241.1(4)(f), s.241.1(5)(c) and s.241.1(5)(d).
[28] *Ibid.*
[29] *Carter v Canada (Attorney General)*, 2012 BCSC 886, at para 400
[30] *Ibid,* at s.241.1(4)(d) and s.241.1(5)(c).
[31] *Ibid*, at s.241.1(6).
[32] *Ibid*, at s.241.1(6)(b).

This would serve to compel health ministries to provide further support, to which persons ought to be seen to have right which is at least as strong as the right to PAS.[33]

The Review Board Process

This documentation, along with the assessments of the Responsible and Consulting Physician, is then submitted with the application to a Review Board.[34]

Unlike Review Boards in other regimes where PAS is legal, apart from Colombia, this decision would be made prior to granting a request for PAS, rather than an *ex post facto* review of a physician's decision based on a form prepared by the physician.

An *ex post facto* review process risks inaccurate results as to whether the criteria were in fact met, as a physician filling out a form after he or she has administered PAS is unlikely to report anything that would leave him or her open to potential criminal prosecution. The only prosecution in a Benelux country involved a physician who chose to elaborate on what was stated on the form through the media.[35] The prosecution did not result from *ex post facto* monitoring, but the physician's decision to speak candidly through the media much later.

Moreover, an *ex post facto* review process is more likely to result in "criterion creep" as is currently being seen in the Benelux regimes where rates of PAS have increased more than 40% annually.[36]

The Review Board is an existing provincial/territorial body with its meaning set out in section 672.38 of the Criminal Code.[37]

The use of the Not Criminally Responsible Review Board is proposed in the draft legislation as it is the only review board that exists in every province and territory. Moreover, the constitutionality of this process has been established.

This does not mean a separate review board could not be established pursuant to federal legislation and provincial implementation. However, it is anticipated that the number of applications for PAS will be sufficiently low so as not to require the establishment of a separate review board.

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[33] Consider whether a *Charter* right to palliative care should not be found based on the same s. 7 arguments that prevailed in *Carter* as well as a s. 15 under inclusion challenge to the *Canada Health Act*, R.S.C., 1985, c. C-6.

[34] *Ibid*, at s.241.1(9).

[35] Haeme, Gramilton. "Belgian doctor facing possible murder charge for euthanizing senior seen as warning for Canada." National Post. October 29, 2015. Available online at <http://news.nationalpost.com/news/belgian-doctor-facing-possible-murder-charge-for-euthanizing-senior-seen-as-warning-for-canada>.

[36] Numbers sourced from Reasons for Judgment of the British Columbia Supreme Court dated June 15, 2012 at para. 400 (*Carter* JR, Vol. II at 230) [TJ Reasons] at paras. 475, 518; Steve Doughty, "Don't Make Our Mistake," Daily Mail, July 9, 2014 (*Carter* BOA, Tab 10). **Appended at Tab 3.**

[37] *Criminal Code*, R.S.C., 1985, c. C-46, at s. 672.38(1).

The composition of the Board currently includes one member entitled under the laws of the province to practice psychiatry and at least one other with training and experience in the field of mental health (and entitled to practice medicine or psychology). It is chaired by a judge of the Federal Court or of a superior, district or county court of a province.[38]

Although there are similarities between the issues requiring determination under PAS as under the Not Criminally Responsible provision, which makes the use of the existing Review Board appropriate, its composition would nonetheless need to be expanded for this new role of assessing PAS requests. This would be left to the provinces to regulate.

Furthermore, there is nothing to stop provinces and territories from cross-appointing members from other boards, such as Ontario's Consent and Capacity Board. Cross-appointments are a standard practice among administrative tribunals in Ontario. Unfortunately, comparable tribunals do not exist in the other provinces and territories.

However constituted, each panel of the Review Board should be chaired by a federally appointed Judge to ensure consistency in reasons for judgments.

The Review Board is intended to set a national standard for criteria and safeguards for accessing PAS, rather than one that varies by province or across physicians.

The fact that the Review Board, comprised of medical and lay experts, makes the ultimate decision, rather than physicians being forced to act as "judge, jury and executioner", would result in a larger panel of willing physicians, rather than the small cadre of assisted suicide "specialists" currently found in the Benelux regimes.

This system also encourages the Responsible Physician, who knows the Patient best, to remain involved, whether or not he or she is ultimately the one who administers PAS.

The Board would conduct an independent, case-by-case administrative review of the PAS request, the clinical evaluations, and the counsellor's documentation (if applicable) prior to the request being carried out.[39] It would also make a determination on competence to consent as well as on possible sources of coercion and undue influence through a multi-party process involving consultation with next-of-kin, the Responsible and Consulting Physicians, the provincial equivalents of Ontario's Office of the Public Guardian and Trustee, and the counsellor if applicable.[40]

The Review Board, when making its decision, would have access to information required to accompany the Patient's application, the Patient's medical record including records of any prior withdrawn or rejected applications, results of any investigation of abuse deemed appropriate by the Office of the Public Guardian and Trustee and information from Third-Parties granted standing.[41]

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[38] *Ibid.*, at s. 672.39.

[39] Draft Federal Legislation, *supra* note 7 at s.241.1(10).

[40] *Ibid.*

[41] *Ibid.*

This would ensure that there is strict compliance with the criteria established by the Court and the other safeguards outlined in the proposed bill, that the Patient has been afforded every reasonable opportunity to come to terms with his or her condition, and that there has been every opportunity to alleviate suffering through medically necessary treatment, including palliative care, and alternative supports, including family involvement.

The involvement of next-of-kin is an important element of the appended legislation,[42] as it may assist the Patient in addressing any sources of vulnerability (i.e. family support may be a solution to isolation) or assist the Board in identifying sources of coercion (i.e. family members who stand to benefit financially or in other ways from the Patient's death may also be a source of abuse).

It need not be an onerous process, or a hardship for the Patient. The process would vary depending on the circumstances of the specific request. Some requests, involving greater potential for vulnerability, would require a hearing before the Review Board, while cases that clearly meet the criteria and exhibit no suggestion of vulnerability may be approved administratively.[43] An expedited process would be available to Patients experiencing intense suffering caused by a sudden and unforeseeable deterioration in his or her condition or illness (i.e. it could be available within 45 days for someone whose circumstances are akin to that of the late Dr. Donald Low).[44]

The Review Board can approve or deny an application administratively that clearly does or does not meet the criteria.[45] Alternatively, the Review Board can require a hearing be held if it feels further questions must be asked (i.e. regarding vulnerability).[46] The person requesting PAS need not necessarily attend the hearing, and a failure to attend does not mean the person withdraws their request or that it automatically would not be granted. The reasons for the inability to attend would be considered. It is also possible for the hearings to be conducted via telephone or video, which would serve to enhance access to rural and remote persons.

Following a hearing, the Review Board can approve an application, deny an application, or adjourn it for a number of reasons,[47] including whether it feels it does not have the information it requires and directs more evidence be produced, whether it does not find the appropriate Consulting Physician was selected (meaning there needs to be a sincere effort on the part of the Patient and the Responsible Physician to find the appropriate physician), or whether it has identified vulnerability. A vulnerable person may still meet the criteria for PAS, but the Review Board may require a greater period of

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[42] *Ibid*, at s.241.1(7).
[43] *Ibid*, at s.241.1(10)(b).
[44] *Ibid*, at s.241.1(10)(c).
[45] *Ibid*, at s.241.1(11).
[46] *Ibid*, at s.241.1(10)(d).
[47] *Ibid*, at s.241.1(11).

time lapse to provide an opportunity to address the source of vulnerability (eg. a period of time for a person to come to grips with his or her new disability).

Administering Physician-Assisted Suicide, Criminal Sanctions & Data Gathering

Once the Review Board has made a decision to grant a PAS request, it is not necessarily the Responsible or Consulting Physician who would administer the PAS. Rather, the Patient would then have access to a panel of willing "Assisting Physicians", provided by the Province, who would administer the PAS.[48]

The appended legislation also notes criminal and civil sanctions for involvement in acts of PAS not in line with the criteria set out in the proposed bill.[49] Liability of physicians is largely foregone by the Review Board assuming responsibility for ensuring procedural and substantive compliance with the law and the adequate protection of the vulnerable.

Finally, the appended legislation calls for data gathering for monitoring/reporting purposes, including data indicating the reasons why Patients seek PAS and the efficacy of alternative interventions including access to necessary medical treatment such as appropriate palliative care.[50]

MORE ON THE PRIOR REVIEW BOARD PROCESS

Critics of a scheme for prior review argue that the circumstances of PAS are more analogous to the scheme for prior review of requests for abortion, which was found to be unconstitutional by the Supreme Court of Canada in *R v Morgentaler,* [1988] 1 SCR 30. The Court in this case found that the prior review process was unconstitutional as it resulted in minimal access and undue delay, resulting in increased risks to women.[51]

The system being reviewed in *Morgentaler* is distinguishable from what is presented in the appended legislation for a number of reasons. In *Morgentaler*, the Court cited that almost ¼ of hospitals did not have enough staff to establish a review board and only 20% of eligible hospitals had actually established a committee.[52] In the case of the appended legislation, the Review Board is already established under the *Criminal Code*. Although its name would be changed and its composition would necessarily need to be expanded to address its new responsibilities, there is no reason why the process contemplated in the appended legislation could not be as informal and flexible as is presently the case for those using the Review Board pursuant to the 'Not Criminally Responsible' provisions.

In terms of access for rural and remote persons, this would be addressed through telehealth, and teleconference or electronic hearings. In some cases, it is not even

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[48] *Ibid,* at s.241.1(11)(b).
[49] *Ibid*, at s.241.1(17).
[50] *Ibid,* at s.241.1(11)(c).
[51] *R v Morgentaler,* [1988] 1 SCR 30, at p 58-59 ["*Morgentaler*"].
[52] *Ibid*, at p 67.

necessary for an individual to be present at the hearing if sufficient information is available.

Moreover, Board members would have clear language and instruction on interpretation,[53] unlike the reviewing committee under the abortion scheme, which was required to apply vague and undefined standards such as the "life or health" of the woman.[54]

The risks to those requesting PAS would not be analogous to the risks to women in delaying abortion through a lengthy approval process, as palliative care should be available in the interim. However, as elaborated above, the process contemplated is not a lengthy one, with an expedited process where even a 45 day turnaround time would frustrate the purposes of the proposed Bill.

Abortion is not an apt analogy for PAS. The Court did not approve "PAS on demand". Rather, it expressly directed that a stringent and complex regulatory scheme be established.[55] If the criteria are not met, the Physician can be charged and convicted under the *Criminal Code*. Likewise, Parliament would not re-enact criminal sanctions against assisted suicide without specifying safeguards and criteria for distinguishing between legal acts of PAS and a criminal act.

The safeguards needed to protect those who are vulnerable, along with the application of eligibility criteria, require consistent application across the country, regardless of the personal philosophies of the physicians involved. Patients making decisions about whether or not to terminate life sustaining treatment are entitled to suicide prevention counselling, taking many forms including social work and case management; all rules analogous to that of the vulnerability counsellor in the Bill. For all these reasons the prior Review Board process can be confidently stated as enhancing rather than limiting rights of Patients seeking PAS as well as their physicians.

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[53] Draft Federal Legislation, *supra* note 7 at s.241.1(1).
[54] *Morgentaler, supra* note 48 at p 68.
[55] *Carter, supra* note 1 at para 125.

TAB 1

Draft Federal Legislation to Amend the Criminal Code to be Consistent with *Carter v. Canada (Attorney General)* 2015 SCC 5

David Baker and Gilbert Sharpe*

An Act to amend the Criminal Code as it relates to Physician-Assisted Suicide and the Review Boards provisions

Her Majesty, by and with the advice and Consent of the Senate and House of Commons of Canada, enacts as follows:

(a) The following be added to s.14:

"except as provided in s.241.1."

(b) Section 21 unchanged being "aiding and abetting."

(c) Section 22 unchanged being "counselling."

(d) The following be added to s. 241(b):

"except as provided in s. 241.1."

(e) The heading preceding s.241.1 shall be:

"Physician-Assisted Suicide."

(f) The following new section be added following s.241:

241.1(1) Interpretation

"Adult" means a person of the age of majority in the province or territory in which he or she resides;

"Application" means a formal Request that includes a Patient's medical records, Witness attestations and Reports submitted to the Review Board for consideration of Physician-Assisted Suicide;

"Assistance" means the provision of knowledge, means or both;

"Assisted Suicide" means the act of intentionally killing oneself with the Assistance of an Assisting Physician who provides the means;

"Assisting Physician" means the Physician involved directly in Physician-Assisted Suicide;

"Responsible Physician" means the Physician who has primary responsibility for the care of the Patient and treatment of the Patient's Irremediable condition and

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* Assisted by Rebeka Lauks.

has a sufficient Patient relationship to allow him or her to provide relevant information concerning the requirements of Physician-Assisted Suicide;

"Competent" means the capacity to understand the subject-matter in respect of which a decision must be made and able to appreciate the reasonably foreseeable consequences of that decision or lack of decision;

"Consulting Physician" means a Physician who is qualified by specialty or experience to form a professional opinion about the matter on which he or she has been consulted;

"Counselling" means one or more consultations as necessary between a Patient and a person, whether or not a member of a regulated health profession, who, through training or experience, is in the opinion of the Responsible or Consulting Physician able to address with the Patient the causes of the Patient's potential Vulnerability;

"Free Request" means a Request made voluntarily (i.e., without coercion or undue influence) to the Review Board;

"Grievous" means a condition or disease which notwithstanding receipt of Medically Necessary treatment, qualified Counselling or available treatment, is capable of causing extreme suffering that a reasonable Patient may consider to be intolerable;

"Informed Consent" means an express choice made after the Patient has been provided with sufficient information to evaluate the risks and benefits of Physician-Assisted Suicide and other alternative courses of actions, including, but not limited to, home care, comfort care, hospice care and pain control, that a reasonable Patient in the same circumstances would require in order to make a decision about the course of action; and the Patient received responses to his or her Requests for additional information about those matters;

"Irremediable" means a terminal disease that is incurable and has been medically confirmed by a Physician, and will by evidence-based medicine and using reasonable judgment, produce death;

"Medically Necessary" means treatment, including palliative care, that is fully funded by the respective provincial or territorial government and is delivered based on the Patient's need, not their ability to pay;

"Patient" means a resident as that term is defined in the *Canada Health Act* under the care of a Physician;

"Personal Representative" means a neutral individual assisting the Patient file an Application with the Review Board or if the Patient does not have a Personal Representative, an Advisor appointed on Request by the Review Board;

"Physician" means a doctor of medicine licensed to practice medicine under the laws of the province or territory in which he or she practices and in good standing with the applicable provincial or territorial college;

"Prognosis" means predicting the likely outcome of Patient's current standing including an estimate of when the disease or illness will cause death;

"Proportionate Palliative Care" means palliative care appropriate to the needs of the Patient whether or not such care is available to the Patient;

"Request" means a wish to proceed with Physician-Assisted Suicide asked for by a Patient in writing;

"Reports" means documents drafted by the Consulting Physician, Responsible Physician, and Counsellor sent to the Review Board as part of the Application for Physician-Assisted Suicide;

"Review Board" has the meaning set out in s.672.38;

"Vulnerable" means a Patient making a Request who in the opinion of the Patient's Responsible or Consulting Physician may be experiencing some or all of the following, any one of which could induce a person to commit suicide:

(a) Lack of access to Medically Necessary treatment including Proportionate Palliative Care;

(b) Lack of access to alternative services necessary for the Patient to lead an independent, dignified and comfortable life;

(c) Lack of the opportunity to come to terms with the Patient's prognosis;

(d) Lack of awareness of how persons with an illness or condition comparable to that of the Patient have nevertheless come to live meaningful and dignified lives;

(e) Social isolation, loss of independence, poverty, fear of becoming a burden on others, or a self-image weakened by anticipated exclusion, disadvantage or discrimination; or

(f) Diminished competency due to a psychiatric or psychological disorder or depression capable of causing impaired judgment;

"Witness" means an individual of the age of majority under applicable provincial or territorial laws who is not a relative (by blood, marriage, or adoption), an owner, operator or employee of the health care facility in which the person making the Request is receiving treatment, or a resident, a Physician involved in the care of the Patient, or at the time of acting as a Witness entitled to any portion of the estate upon death under any will or by operation of law.

s.241.1(2) Initiating a written Request for an Application by a Patient for Physician Assistance to commit Suicide

(a) An Adult Patient who is Competent, free from coercion and undue influence may make a written Application to a Review Board set out in subsection 672.38 (1) to be permitted to commit Suicide with Physician Assistance.

(b) A copy of the complete Application shall be simultaneously transmitted to the Public Guardian and Trustee of the province or territory.

(c) An Application to the Review Board shall include a Report from the Patient's Responsible Physician, a Report from at least one Consulting Physician, a Report from the Counsellor, if such a referral has been made by the Responsible Physician or Consulting Physician, Witness attestations, and the Patient's medical record containing at a minimum, a record of all Requests made by the Patient for Physician Assistance to commit Suicide, and all revocations of any such Request.

(d) No Patient shall qualify under the provisions of Physician-Assisted Suicide solely because of age or disability.

(e) Any person who pursuant to ss. (14) receives a verbal or written revocation of the Patient's Request for Physician-Assisted Suicide shall advise the Patient's Responsible Physician and notify the Review Board as soon as reasonably possible, and the revocation shall terminate the Request for all purposes.

s.241.1(3) Form of the written Request

(a) A valid Request for Physician-Assisted Suicide shall be signed and dated by the Patient in the presence of the Responsible Physician and witnessed by at least two individuals who, in the presence of the Patient, attest that to the best of their knowledge and belief the Patient is Competent, acting voluntarily, and is not being coerced to sign the Request.

(b) The Request shall include a statement by the Patient that he or she has not been induced or coerced to seek Physician-Assisted Suicide, and shall be accompanied by reasons, stated in the Patient's own words, why the suffering he or she is experiencing is resulting from his or her medical illness or condition and is considered to be intolerable and likely to be enduring.

(c) Before the Application is forwarded to the Review Board and the Public Guardian and Trustee, both the Patient and the Responsible Physician shall confirm in writing that it is complete to the best of their knowledge.

(d) The Witnesses shall be persons who are not:

1. A relative of the Patient by blood, marriage or adoption;

2. An owner, operator or employee of a health care facility where the Patient is receiving medical treatment or is a resident, except as stated in subsection 4; or

3. A person acting as a Witness would be entitled to any portion of the estate of the qualified Patient upon death under any will or by operation of law.

(e) The Patient's Responsible Physician at the time the Request is signed shall not be a Witness but shall record his or her presence at the signing in the Patient's medical record.

(f) If the Patient is a Patient in a long term care facility at the time the written Request is made, one of the Witnesses shall be an individual designated by the facility and having the qualifications specified by the Ministry of Health of the applicable provincial jurisdiction.

s.241.1(4) Responsible Physician responsibilities

The Responsible Physician shall:

(a) Make the initial determination of whether the requesting Patient appears Competent to provide Informed Consent and to be acting voluntarily, and confirm whether or not there appears to be a causal connection between the Patient's condition or disease and the suffering he or she has identified as being intolerable;

(b) Ensure that the Patient is making an Informed decision, such that he or she informs the Patient of:

1. His or her medical diagnosis, including a determination of whether or not the Patient suffers from a disease or condition that is Grievous and Irremediable and an identification of any Medically Necessary treatment, including Proportionate Palliative Care, that could alleviate some or all of the suffering experienced by the Patient;

2. the reasons why the treatment identified as Medically Necessary is not available to the Patient and the circumstances under which it could be made available;

3. His or her Prognosis based on receiving or refusing the Medically Necessary treatment identified, including a statement indicating whether the Patient's death is imminent;

4. The probable result of taking the medication to be administered, in the event the Patient's Request is granted by the Board;

5. The alternative courses of action that could alleviate the Patient's suffering, whether or not readily available, including, but not limited

to Counselling, home care, comfort care, hospice care and pain control, including options for accessing them; and

6. The right to revoke the Request at any time, whether verbally or in writing.

(c) Refer the Patient to at least one Consulting Physician with expertise related to the source of the suffering identified by the Patient for clinical advice;

(d) Refer the Patient for Counselling if the Patient may be Vulnerable;

(e) Advise the Patient that next-of-kin may be contacted or assign this responsibility to the Counsellor;

(f) Draft a Report to accompany the Application for the Review Board detailing: (i) the basis for perceiving the Patient is Competent; (ii) the information that was provided to the Patient and a confirmation that in the opinion of the Physician it was sufficient for the Patient to make an informed decision; (iii) the basis for concluding the condition or disease is Grievous and Irremediable, including a Prognosis regarding death is expected to occur within 12 months; (iv) Medically Necessary Treatment or alternative services that were recommended; (v) the basis for a referral to Counselling, if applicable, and (vi) the independence of the Patient's request and the role of the next-of-kin in accessing alternatives;

(g) Where the Responsible Physician contacts the next-of-kin, he or she shall attempt to determine what if any impact family members had on the voluntariness of the Patient's Request and establish whether the family was willing and able to support the Patient in accessing Medically Necessary treatments and alternative services. This information shall form part of the Responsible Physician's Report to the Review Board;

(h) Inform the Patient upon receipt of a Request that he or she has an opportunity to rescind the Request at any time and in any manner, and offer the Patient an opportunity to rescind the Request immediately prior to submission of the Application to the Review Board;

(i) Ensure that all appropriate steps are carried out in accordance with subsections 241.1(2)(2) and (9) prior to the Patient making an Application to the Review Board; and

(j) Confirm that all responsibilities under this Section have been performed.

s.241.1 (5) Consulting Physician confirmation

After the Patient informs the Responsible Physician that he or she wishes to commit Suicide with Physician Assistance, at least one Consulting Physician shall:

(a) Examine the Patient and his or her relevant medical records and develop an independent position, in writing, as to whether or not the Patient is suffering from a Grievous and Irremediable medical disease or condition;

(b) Examine the Patient and his or her relevant medical records and determine if Medically Necessary treatment exists that in their opinion could alleviate or help alleviate the suffering described by the Patient;

(c) Refer the Patient for Counselling if, in his or her independent opinion, the Patient may be Vulnerable;

(d) Draft a Report to accompany the Application for the Review Board detailing, in the Consulting Physician's independent opinion: (i) whether or not the Patient is Competent, and the basis for this conclusion; (ii) the information that was provided to the Patient and a confirmation that it was sufficient for the Patient to make an informed decision; (iii) the basis for concluding the condition or disease is Grievous and Irremediable, including a Prognosis regarding whether death is expected within 12 months; (iv) the Medically Necessary Treatment or alternative services that were recommended; and (v) the basis for a referral to Counselling, if applicable; and

(e) Confirm that all responsibilities under this Section have been performed.

s.241.1 (6) Counselling referral

(a) Counselling, whether publicly or privately funded, shall be made available if:

1. The Patient makes an oral or written Request; or
2. In the independent opinion of the Responsible Physician or the Consulting Physician, a Patient may be Vulnerable.

(b) The Counsellor shall draft a Report to accompany the Application for the Review Board detailing: (i) whether the Patient attended and completed the recommended course of Counselling; (ii) the sources of Vulnerability addressed with the Patient; (iii) the impact the Counselling had on the suffering experienced by the Patient; and (iv) whether the Patient accessed the treatments and alternative services available that could alleviate his or her suffering.

(c) Where the Responsible Physician assigns responsibility to the Counsellor for informing the Patient's next-of-kin of the Request for Physician-Assisted Suicide, the Counsellor shall attempt to determine what impact family members had on the Patient's Request and establish whether the family was willing and able to support the Patient in accessing Medically Necessary treatments and alternative services.

(d) No medication to end a Patient's life shall be administered until the person Counselling the Patient determines that the Patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(e) The Counsellor shall confirm in writing that all responsibilities under this Section have been performed

s.241.1(7) Next-of-kin Notification

The Responsible Physician shall advise the Patient that the next-of-kin will be informed of his or her Request for Physician-Assisted Suicide and will be asked to provide information concerning the Patient, and that this information shall form part of the Application.

s.241.1(8) Public Guardian and Trustee

(a) Upon receipt of an Application, the Public Guardian and Trustee shall exercise the powers of the office to conduct such investigation as is deemed necessary, including contacting the Patient's next-of-kin, and based on the Application and the results of the investigation, advise the Review Board of whether an oral hearing is warranted.

(b) When there is an oral hearing, the Review Board shall notify the Public Guardian and Trustee to participate as a full party in the proceeding, with power *inter alia* to summon persons to give oral testimony, introduce documentary evidence, examine persons giving oral testimony and make submissions.

s. 241.1(9)Medical Record Documentation requirements for the Application

The Responsible Physician shall ensure that the following be documented and filed in the Patient's medical record that shall be provided together with the Request and the Reports to the Board by the Patient or Personal Representative:

(a) Any oral Requests by a Patient for Physician-Assisted Suicide, including any previous Requests;

(b) All written Requests by a Patient for Physician-Assisted Suicide;

(c) The Responsible Physician's diagnosis and Prognosis, including a determination of whether the person is suffering from a Grievous and Irremediable condition;

(d) The Responsible Physician's determination as to whether or not the Patient is Competent to make the Request;

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(e) The Responsible Physician's opinion on whether the Patient is acting voluntarily and has made an Informed decision;

(f) A record of all Medically Necessary treatment, including palliative care capable of alleviating some or all of the suffering experienced by the Patient, including an indication of whether the treatment was accepted or refused by the Patient and if accepted, whether or not the treatment was available and administered, and the observed consequence of receiving treatment on the Patient's suffering;

(g) One or more of the Consulting Physician's diagnosis and Prognosis, and verification that the Patient is Competent and has made an Informed decision;

(h) The date, names and contact information of the Witnesses who attested to the Patient's Request for Physician-Assisted Suicide;

(i) Any recommendations for the Patient to inform their next-of-kin, and whether or not to the knowledge of the person making the recommendation, the next-of-kin was informed;

(j) A Report of the outcome and determinations made during Counselling, if performed;

(k) The Responsible Physician's offer to the Patient to rescind his or her Request at the time of the Patient's initial Request, second Request and immediately before applying to the Review Board for a determination on Assisted Suicide;

(l) A record of any verbal or written revocation statements to the Request made by the Patient; and

(m) A note by the Responsible Physician indicating that all requirements under subsections 241.1(2)(2) and (9) have been met.

s.241.1(10) Application to Review Board

(a) A Patient or Personal Representative shall make a written Application to the Review Board that includes the requirements set out in subsection241.1(2)(2), including the Reports and the Witness attestations.

(b) An Application does not require an oral hearing unless:

1. The Patient chooses a hearing;
2. The Public Guardian and Trustee or the Board makes a determination that a hearing is required; or
3. A third-party makes an objection to the Review Board concerning the Patient's choice to undergo Physician-Assisted Suicide.

(c) The Board may follow an expedited process where the Responsible or Consulting Physician provides information indicating that the Patient is experiencing intense suffering caused by a sudden and unforeseeable deterioration in the Patient's condition or illness.

(d) The Board shall determine that an oral hearing is required where any of the following is apparent based on the Application, Request, the Witness attestations and the Reports submitted where:

1. The Patient has refused consent to either a treatment identified by a Physician as being Medically Necessary, or to attend and complete Counselling with a Counsellor to whom the Responsible Physician or Consulting Physician has made a referral;
2. A Physician expresses in their Report that the Patient's condition is not Grievous or Irremediable;
3. A Request has been initiated and withdrawn or has been previously rejected by the Board; or
4. The Patient's disease or condition is identified as being Irremediable, however a Physician is of the opinion that the disease or condition is unlikely to cause death within a twelve month period from the date of the Request.

s.241.1(11) Order from the Review Board

(a) The Board, having reviewed the record filed with the Request, and based on the evidence received at the oral hearing, if any, shall make one or more of the following orders:

1. Grant the Request following a determination that the Patient is Competent and is suffering from a Grievous and Irremediable condition or illness that is the cause of suffering considered to be intolerable by the Patient;
2. Deny the Request;
3. Adjourn the Request and direct that members of the Patient's next-of-kin be notified of the Request and the proceeding before the Review Board, with a Request for their participation;
4. Adjourn the Request with a direction that the Application or course of Counselling is incomplete and needs to be completed before an amended Application is re-submitted;
5. Adjourn the Request with a direction that a Physician or Counsellor appear and give testimony before the Board; or

6. Adjourn the Request with a direction that further evidence is required by the Board before it is prepared to make an order.

(b) A Patient having received an order to proceed with Physician-Assisted Suicide may select an Assisting Physician from a regional roster, maintained by the province or territory in which the Patient resides, of physicians willing to administer the dose of medication causing death.

(c) The Board shall report the Request, the nature of the suffering identified by the Patient, whether the Patient was unable or unwilling to access Medically Necessary treatment or alternative services, its order, together with forwarding the Report of the Assisting Physician, if any, to the Canadian Centre for Justice Statistics of Statistics Canada, which shall compile this information and present an Annual Report to Parliament.

s.241.1 (12) Informed decision

No Assisting Physician shall directly administer the medication causing death to a Patient unless he or she has confirms that the Patient made a voluntary and Informed decision. Immediately prior to administering the dose triggering death, the Assisting Physician shall verify that the Patient is making an Informed decision.

s.241.1 (13) Assisting Physician Responsibilities

The Assisting Physician shall:

(a) Offer the Patient an opportunity to rescind his or her Request for Physician-Assisted Suicide;

(b) Administer the medication causing death; and

(c) Report the Physician-Assisted Suicide, or rescission of the Request, to the Review Board.

s.241.1 (14) Right to rescind Request

A Patient may rescind his or her Request at any time and in any manner (oral or written) without regard to his or her mental state. Physician Assistance may not be provided to aid a Patient to commit Suicide without the Responsible Physician, Consulting Physician, Counsellor, if any and Assisting Physician offering the Patient an opportunity to rescind the Request.

s.241.1 (15) Insurance or annuity policies

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a Request, by a person, to end his or her life by Physician-Assisted Suicide. Neither shall a Patient's act of ingesting medication to end his or her life in by Physician-Assisted Suicide have an effect upon a life, health, or accident insurance or annuity policy.

s.241.1 (16) Billing - Physicians

An Assisting Physician shall not submit his or her accounts under any provincial or territorial health insurance plan for performance of the services for Physician-Assisted Suicide.

s.241.1 (17) Offences and penalties

(a) A person commits an offence if he willfully falsifies or forges a declaration made under this Act with the intent or effect of causing the person's death. A person guilty of an offence under this subsection shall be liable, on conviction, to imprisonment for a term not exceeding twenty-five years.

(b) A person commits an offence if he encourages, coerces or unduly influences a Patient to choose Physician-Assisted Suicide. A person guilty of an offence under this subsection shall be liable, on conviction, to imprisonment for a term not exceeding twenty-five years.

(c) A Witness commits an offence if he willfully puts his name to a statement he knows to be false. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(d) A person commits an offence if he willfully conceals or destroys a declaration or revocation made under this Act. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(e) A Physician or Counsellor with responsibilities in relation to an Application or an order of the Board commits an offence if he or she willfully fails to submit the information required under subsections (4), (5) and (6). A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

(f) An Assisting, Responsible or Consulting Physician involved in the care of a Patient commits an offence if he takes any part whatsoever in assisting a Patient to die or in giving an opinion in respect of such a Patient, or acts as a Witness if he has grounds for believing that he will benefit financially or in any other way as the result of the death of the Patient. A person guilty of an offence under this subsection shall be liable on conviction to imprisonment for a term not exceeding five years.

s.241.1 (18) Inconsistencies

(a) Where there is any inconsistency or conflict between this section and any other provision of this Act or any other federal legislation, this section prevails to the extent of the inconsistency or conflict.

The following revisions to be made to s.672.38:

(a) A Review Board shall be established or designated for each province to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is rendered, and <u>concerning matters related to Physician-Assisted Suicide</u> and shall consist of not fewer than five members appointed by the lieutenant governor in council of the province.

TAB 2

Disability Rights and Wrongs

By Tom Shakespeare

Excerpt: pages 129-130

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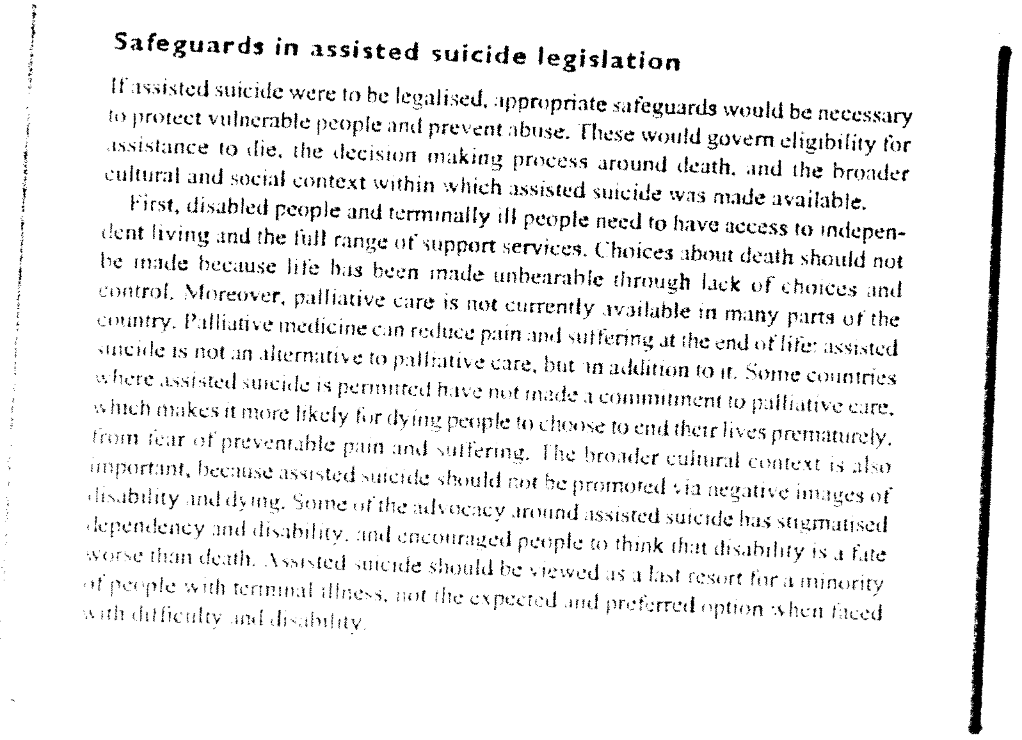


Safeguards in assisted suicide legislation

If assisted suicide were to be legalised, appropriate safeguards would be necessary to protect vulnerable people and prevent abuse. These would govern eligibility for assistance to die, the decision making process around death, and the broader cultural and social context within which assisted suicide was made available.

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. Moreover, palliative care is not currently available in many parts of the country. Palliative medicine can reduce pain and suffering at the end of life: assisted suicide is not an alternative to palliative care, but in addition to it. Some countries where assisted suicide is permitted have not made a commitment to palliative care, which makes it more likely for dying people to choose to end their lives prematurely, from fear of preventable pain and suffering. The broader cultural context is also important, because assisted suicide should not be promoted via negative images of disability and dying. Some of the advocacy around assisted suicide has stigmatised dependency and disability, and encouraged people to think that disability is a fate worse than death. Assisted suicide should be viewed as a last resort for a minority of people with terminal illness, not the expected and preferred option when faced with difficulty and disability.

Second, promoting autonomy should be balanced with protection, even if this verges on paternalism. Questions of definition need close attention in developing regulation of assisted suicide. The distinction between 'people with terminal illness' and 'terminally ill people' is very important, and not easy to specify. 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. To broaden the eligible class too widely might be to put disabled people at risk in the way that critics fear.

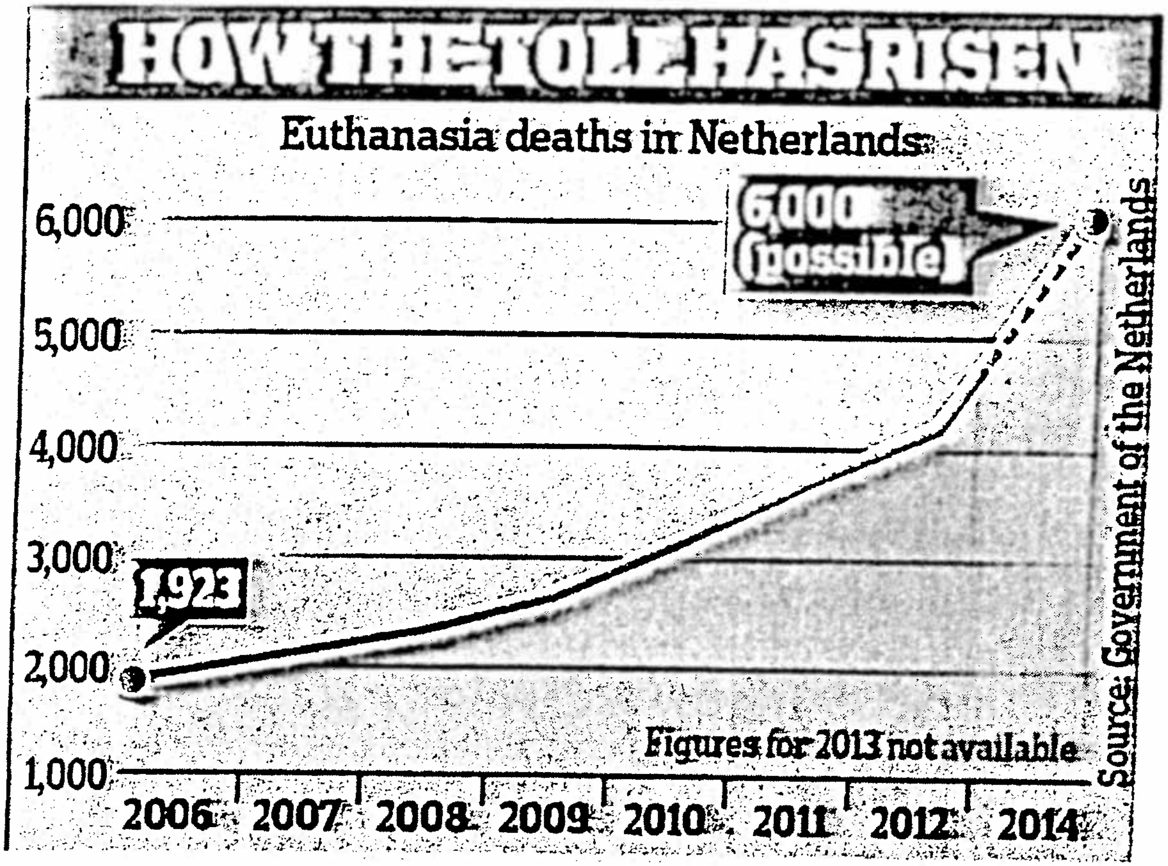
Moreover, it is normal to fear disability and death, and it is often traumatic to incur or be diagnosed with incurable impairment or terminal illness. For example, Disability Awareness in Action quote Dr Ian Basnett, a quadriplegic, as saying of the period after the accident which left him quadriplegic, 'I was ventilator dependent for a while and at times said to people "I wish I was dead!" I am now extraordinarily glad no one acted on that and assisted suicide was not legal' (Hurst, n.d.). Experience shows that the initial anger and distress at diagnosis often gives way to a more balanced and accepting attitude over time. Therefore, 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. Understanding the complex fears and yearnings of those who desire euthanasia is important (Wood Mak and Elwyn, 2005).

Moreover, even people in the eligible category may not always be able to make a rational decision to request death. For example, depression and other mental illness could cloud judgement and may prevent a person with terminal illness making a competent decision to request death. The right to request assisted suicide should depend on the mental competence of the person with terminal illness. Disabled people may become depressed at pain and restriction, and express desire to die. For example, Alison Davis (2004) discusses a phase in her life when this was the case for her. She fears that had it been legal, she would have requested assistance and suggests that most requests for death stem from depression.

Any request for assisted suicide should be subject to calm and careful scrutiny from both medical and legal professionals. Once a request has been made and approved, there should be a 'cooling-off period' for the person to consider their situation, at the end of which they should have to confirm once more that they understand the consequences of their decision and want to go ahead with assisted suicide.

Assisted suicide should only ever be available in very restricted circumstances: the end stage of terminal, incurable illness, when suffering becomes unbearable. Legalisation and regulation should be carefully framed, to ensure that the 'slippery slope' which opponents fear cannot occur.

TAB 3



How the toll has risen: The Netherlands has seen deaths double in just six years

His native Netherlands, where euthanasia has been legal since 2002, has seen deaths double in just six years and this year's total may reach a record 6,000.

Professor Boer's intervention comes as peers prepare to debate the Assisted Dying Bill, promoted by Lord Falconer, a Labour former Lord Chancellor.

The bill, which has its second reading next week, would allow doctors to prescribe poison to terminally ill and mentally alert people who wish to kill themselves.

Professor Boer, who is an academic in the field of ethics, had argued seven years ago that a 'good euthanasia law' would produce relatively low numbers of deaths.

NETHERLANDS

	Year	AS/E Deaths	Total AS/E Deaths
Trial Judge Numbers (para. 475)			
	1990	204	204
	1995	346	550
	2001	377	927
Source: Netherlands Annual reports*			
	2002	1,882	2,809
	2003	1,815	4,624
	2004	1,886	6,510
	2005	1,933	8,443
	2006	1,923	10,366
	2007	2,120	12,486
	2008	2,331	14,817
	2009	2,636	17,453
	2010	3,136	20,589
	2011	3,695	24,284
	2012	4,118	28,402
Total		28,402	

	Percent Increase (%)
Netherlands Annual Reports Only	11.88
Not including First Year	64.13

* As cited in Parliament of Canada, "Euthanasia and Assisted Suicide: International Experiences" at s. 4.3 - http://www.parl.gc.ca/content/lop/researchpublications/2011-67-e.htm

2002 numbers directly from Annual Report available at http://www.afm.nl/en/professionals/afm-actueel/jaarverslagen/2002.aspx

BELGIUM

	Year	AS/E Deaths	Total AS/E Deaths
Trial Judge Numbers (para. 518)			
	2002	24	24
	2003	235	259
	2004	347	606
	2005	388	994
	2006	428	1,422
	2007	495	1,917
	2008	705	2,622
Source: Belgium Biannual Reports*			
	2009	822	3,444
	2010	953	4,397
	2011	1,133	5,530
Total		5,530	

	Percent Increase (%)
Not including First Year	47.77
Trial Judge Numbers Only	472.92
Trial Judge Numbers Only (Not including First Year)	40.00

* As cited in Parliament of Canada, "Euthanasia and Assisted Suicide: International Experiences" at s. 6 - http://www.parl.gc.ca/content/lop/researchpublications/2011-67-e.htm

This is Exhibit D referred to in the Affidavit of Michael Bach Affirmed before me this 9th day of December 2015

Commissioner for Taking Affidavits
A Commissioner, etc.

101.

Protecting Choice & Safeguarding Inclusion

A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada

Issued by:

The Canadian Association for Community Living

September 2015

Canadian Association
for Community Living
Association canadienne pour
l'intégration communautaire

Diversity includes. On se ressemble.

The Canadian Association for Community Living (CACL) is a national, family-based association and federation of over 40,000 members, 300 local and 13 provincial/territorial Associations for Community Living. CACL is dedicated to attaining full participation in community life, ending exclusion and discrimination on the basis of intellectual disability, promoting respect for diversity and advancing human rights to ensure equality for all Canadians.

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Plain Language Summary

The Supreme Court of Canada has decided that physician-assisted suicide and voluntary euthanasia are no longer against the law.

- "Physician-assisted suicide" is when a person kills him/herself with the help of a doctor.
- "Voluntary Euthanasia" is when a person asks a doctor to kill him or her.
- In both cases, a doctor gives drugs that will kill the person.

The Court has said that adults should be able to access a system to do this when:

- They have a medical condition that causes them to suffer all the time.
- They can make the decision all by themselves.
- They are not vulnerable to being pushed into dying by other people or their situation.
    - This means that no other person is trying to make them choose to die. Or, that they are choosing to die because of other reasons – like being all alone, poor, unable to support yourself, without people who care about you, or who can assist you to live.

To make sure people have a real choice, and also that vulnerable people are not pushed into dying, we have made a proposal called: *Protecting Choice & Safeguarding Inclusion*. The goal is:

> *To make sure people can choose physician-assisted suicide or voluntary euthanasia, but only as a real choice.. This means they must not be pushed into dying by others, or because of poverty, lack of support, or abuse. Other options must always be provided. The system must safeguard inclusion of vulnerable persons in society.*

Our plan is based on:

1. *Core Values*

- Autonomy – real choice
- Dignity – self-respect and self-worth
- Inclusion – having options and support to live a good life

2. *Principles and Guidelines*

- To put these values into action

3. *Vulnerability Assessment and Informed Consent*

- People who choose to die must first have someone else find out if they are being pushed to die or are vulnerable.
- A person must be able to make, understand and communicate the choice. They must be able to do this by themselves. A person's support network cannot make or communicate this choice for a person.

4. *Advance Independent Review and Approval*

- A request to die should be approved by an independent panel, who will either deny or approve the request. When the panel believes the person is too vulnerable or not able to make this decision on his or her own, it should not be approved.

5. *Independent Monitoring and Public Reporting*

Every year a report should be made to provincial/territorial legislatures and to Parliament about the system. The report should include the number of requests, who requested and why. It should also include any alternatives that were put in place for a person, instead of dying.

6. *More Funding for Palliative Care, Disability and Community Supports*

To make sure people have other options, governments must increase spending on palliative care and community supports for people with disabilities. This is the only way to make sure people have the option of inclusion in their community.

7. *Governments and Community Working*

- The basics of the system need to be in laws at both the federal level and provinces and territories. Safeguards to protect vulnerable people should be in the federal *Criminal Code* to make sure the system is the same across the country.
- Governments must work together to design the system and make sure investments are made in palliative care and disability-related supports in the community. Without this, many people who may want to die, won't feel like they have a real choice to continue living.
- People with disabilities, older persons, and health care providers must all be included in designing and monitoring the system to make sure the right safeguards are put into place.

The disability community was very concerned when the Supreme Court made physician-assisted suicide and voluntary euthanasia legal. We don't people who are already vulnerable to become even more so.

Governments must put more funding into palliative care and community supports. Without that, we are concerned that people will choose to die through assisted suicide or voluntary euthanasia because they don't have another choice. We must make sure people with disabilities have real choices to live good lives in the community, secure and safe from harm, able to live with dignity.

We urge governments and other stakeholders think carefully in creating a system, to prevent outcomes that none of us want. We hope the system will promote choice, dignity and inclusion for all Canadians throughout their lifetimes. We think our proposals can help do that.

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Executive Summary

In *Carter v. Canada,* the Supreme Court struck down the *Criminal Code* prohibition on physician-assisted suicide and voluntary euthanasia. It directed that access must balance the right to choose with safeguarding vulnerable persons who may be induced to commit suicide.

For this purpose, we urge that the system for physician-assisted suicide and voluntary euthanasia be designed to fully account for growing vulnerability in Canadian society, including:

- Increasing prevalence and severity of disability
- Increasing prevalence of mental health difficulties and disability
- Lack of access to disability-related supports
- 70% gap in palliative care
- Poverty and labour force exclusion
- High rates of violence, abuse and insecurity for people with disabilities
- Barriers to health care access
- Rapid increase in cases of dementia
- High rates of depression among seniors in long-term care
- Elder abuse

Our proposal, *Protecting Choice & Safeguarding Inclusion*, aims to ensure that:

> **Adults may gain access to physician-assisted suicide or voluntary euthanasia only on the basis of real and informed choice. They must be free from abuse and vulnerability to lack of support, disrespect, discrimination and devaluation. The system must respect, promote and safeguard inclusion of all persons in society, regardless of their disability or other differences.**

Elements of the Proposed Plan

- ➢ Core Values
- ➢ Principles and Guidelines
- ➢ Vulnerability Assessment in Informed Consent
- ➢ Advance Independent Review and Authorization
- ➢ Monitoring and Public Reporting
- ➢ Investment in Palliative Care and Community Supports
- ➢ Federal-Provincial/Territorial Jurisdiction, Investment, Coordination and Engagement

1. Core Values

The *Carter* decision states that a system for physician-assisted suicide and euthanasia must be guided by three core values: respect for autonomy, dignity, and preservation of life.

- To respect autonomy, the system must make sure that people really *are* making self-determined choices.
- To respect dignity, the system must be grounded on the two dimensions of this value. First, dignity is harmed when a person's autonomy is restricted, as the Court stresses in *Carter.* Second, dignity is harmed when a person's social group is devalued and

disadvantaged on the basis of shared characteristics, certainly the case for people with disabilities. Harming the dignity of whole groups can undermine autonomy because members of devalued groups often become socially and economically marginalized, lose a sense of self-worth, and feel a burden on society.

- To preserve life of people who may be vulnerable to being induced to commit suicide, the system must be designed to promote their inclusion in society, recognizing:
  - that the dignity of people with disabilities and older persons is harmed by the pervasive social and economic vulnerabilities of these groups; and
  - that the experience of indignity and vulnerability can, but not necessarily does, undermine autonomy of these persons.

We strongly believe that adequate safeguards for this purpose must include inquiry into whether conditions of vulnerability are affecting a person's choice for physician-assisted suicide or voluntary euthanasia.

2. *Principles and Guidelines*

The system should be designed, managed and accountable according to key principles of:

- real autonomy;
- understanding of conditions of vulnerability and harm to dignity;
- protection against inducement to commit suicide;
- engagement of persons with disabilities and their organizations in design and oversight.

Specific guidelines should include:

- informed consent on the basis of legal independence;
- disability, in and of itself, is not a grievous and irremediable condition;
- clinical input from at least two physicians;
- advance authorization by an independent review panel to consider: reasons, eligibility, timeliness, decisional capacity, and assessment of alternative courses of action;
- monitoring and annual reports to Parliament and provincial/territorial legislatures;
- provision for an expedited process to ensure compassion can be exercised in situations where criteria are clearly met and death is imminent or in the near future;
- distinguishing physician-assisted suicide and voluntary euthanasia from palliative care.

3. *Vulnerability Assessment in Informed Consent*

A 'vulnerability lens' must be applied in all cases. Where risk of vulnerability to inducement is identified, steps must be taken to explore and provide appropriate supports for people who may request assistance to die, but who are in fact vulnerable because of social and economic circumstances.

A qualified assessor is needed to undertake a full vulnerability assessment and consideration of alternative courses of action, many of which will be of a community and social support nature. This exploration is beyond the mandate and training of physicians.

4. *Advance Independent Review and Authorization*

Advance independent review and authorization of requests for physician-assisted suicide and voluntary euthanasia, along with an appropriate waiting period, is the only way to ensure that requests are not subject to undue influence or misapprehension. This will ensure:

- principles of autonomy, dignity and inclusion are applied in every case
- adequate assessment of vulnerability and alternatives;
- decisions about whether to authorize or report a death are out of the hands of physicians;
- ongoing trust of family physicians by removing them from authorization of the interventions;
- an expedited process where warranted;
- protection against loosening criteria for eligibility.

5. *Independent Monitoring and Public Reporting*

On an annual basis, independent review bodies in each province and territory should report on requests and outcomes to their respective legislatures, and a federal authority should report to Parliament.

6. *Needed Investment in Palliative Care, Disability and Community Supports*

Increasing disability, entrenched poverty and a growing gap in palliative and disability-related supports, means social vulnerability is growing. Requests for physician-assisted death and voluntary euthanasia may grow as a result. Governments must invest to close the gap in palliative care and disability supports so that Canadians have real choice and alternatives.

7. *Shared Jurisdiction, Investment, Coordination and Engagement*

- *Federal Criminal Code amendments* – to mandate consistent standards across the country for eligibility, informed consent, vulnerability assessments, waiting periods, and advance independent review and authorization.
- *Provincial/Territorial Regulation* – to regulate access and advance authorization, independent review boards, health professions, health care services, vulnerability assessment, informed consent, adult protection, and legal capacity.
- *Coordinated Investment Strategy* – to ensure adequate and coordinated investment for palliative care and needed disability-related supports.
- *Government-Community Engagement* – to guide development, implementation and investment – with representation from health, disability and older person communities.

The disability community has been profoundly affected by the *Carter* judgment because of the risk it poses to advancing inclusion, equality and human rights for Canadians with disabilities. We hope our proposals help find common ground for a system that protects real choice and safeguards inclusion. We urge that foresight, caution, compassion and core values guide us all in the exercise ahead so that the system will contribute to, rather than undermine, autonomy, dignity and inclusion for all Canadians throughout their lifetimes.

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Introduction

In its judgment in *Carter v. Canada*,[1] the Supreme Court struck down the *Criminal Code* prohibition on physician-assisted suicide and voluntary euthanasia in Canada where:

- A consenting adult has a grievous and irremediable medical condition that causes enduring suffering intolerable to that person; and
- The person is not vulnerable to being induced to commit suicide.

The Court stressed that a system to enable access to physician-assisted suicide and voluntary euthanasia must strike a balance between protecting the right to autonomy and dignity of individuals who make this choice, and protecting vulnerable persons in our society. The Court was clear that a "complex regulatory regime" was justified for this purpose, but that its design was better left to Parliament than the courts.[2]

In light of the *Carter* decision and the disability community's longstanding concerns about assisted suicide, the Canadian Association for Community Living has developed the proposal, *Protecting Choice & Safeguarding Inclusion*, to assist decision makers in designing a system. Our proposed plan provides a means to safeguard inclusion in society for vulnerable persons, while at the same time respecting a decision to choose physician-assisted suicide or voluntary euthanasia because of an irremediable condition that causes enduring and intolerable suffering. Our plan aims to ensure that:

> **Adults may gain access to physician-assisted suicide or voluntary euthanasia only on the basis of real and informed choice. They must be free from abuse and vulnerability to lack of support, disrespect, discrimination and devaluation. The system must respect, promote and safeguard inclusion of all persons in society, regardless of their disability or other differences.**

Significant challenges must be addressed if the system is to fully deliver on this outcome. We urge governments to proceed in a manner acutely aware of the risks, resolved to guard against outcomes none of us want, and committed to building an inclusive and accessible Canada where all are assured of autonomy, dignity and inclusion throughout their lifetimes.

In this report we reference both 'physician-assisted suicide' and 'voluntary euthanasia' to indicate that the scope of our proposal is restricted to these two interventions, as is the *Carter* decision. The Royal Society of Canada 'Expert Panel on End-of-Life Decision Making' defines these interventions as follows:

> *"Assisted suicide" is the act of intentionally killing oneself with the assistance of another. "Voluntary Euthanasia" is an act undertaken by one person to kill another person whose life is no longer worth living to them in accordance with the wishes of that person.*[3]

Why Do We Need a System to Protect Choice and Safeguard Inclusion?

People with disabilities, their families and representative organizations want to make sure a system for physician-assisted suicide and voluntary euthanasia offers real choice in end-of-life decision making. It must ensure that people who are vulnerable to being induced to commit suicide are not placed at risk of preventable death. Motivating our concerns are the widespread conditions of vulnerability experienced by Canadians with disabilities and older persons:

- ***Increasing prevalence and severity of disability, and multiple disadvantage*** – Almost 14% of the adult population in Canada has a disability and this prevalence rate is growing year by year. Women are over-represented in almost all age groups.[4] Among Aboriginal persons, the prevalence of disability is over 30%, with this higher rate due to significant environmental and trauma-related disabilities.[5] Overall there is an increasing prevalence of people with 'severe' or 'very severe' disabilities, currently estimated at 1.8 million adults in Canada.[6] This is a group particularly vulnerable to abuse, social exclusion, and stigma especially those multiply- disadvantaged by gender or ethno-racial-cultural status.
- ***Lack of access to disability-related supports*** – A growing gap in needed disability-related supports affects both people with disabilities and families. Statistics Canada reports that unmet need for support increases with severity of disability, with 49% of people with severe disabilities needing help or not receiving enough help. For people with disabilities not living alone, 80% rely on families for needed support. For those living alone, 56% rely on their families.[7] With the aging of the population this gap will grow substantially – because of increased disability prevalence and more limited capacity of aging family caregivers.
- ***Gap in palliative care*** – 70% of Canadians are not able to access palliative care, [8] which will become a growing issue as annual deaths increase from the current rate of 260,000 deaths per year to more than 425,000 per year by 2036.[9]
- ***Increasing prevalence of mental health difficulties*** – A study for the Mental Health Commission of Canada estimates 20% of Canadians experience mental health difficulties annually, including mood disorders, anxiety disorders, schizophrenia, attention deficit/hyperactive disorders (ADHD), conduct disorders, oppositional defiant disorders (ODD), substance use disorders or dementia. It estimates that within a generation more than 8.9 million Canadians will be living with a mental illness.[10] Among people with disabilities who experience rates of violent victimization much higher than the general population, self-rated poor or fair health status, as well as sleep disorders and use of antidepressants or sedatives, are [11]associated at rates 50% to 90% higher than the average.
- ***Mental health disability and other disabilities co-related*** – Statistics Canada estimates there are over 1 million Canadians with mental health disabilities, which are defined for

population surveys as a long-term condition that limits daily activities. Of this group, almost 92% also report having at least one other type of disability.[12]

- ***Poverty and labour force exclusion*** – Working-age adults with disabilities are about twice as likely to live in poverty as the general population (20.5% versus 11%). Almost 40% of Aboriginal persons with disabilities live in poverty. Persons with severe disabilities are multiply disadvantaged, with over 50% living in poverty. Employment rates are far lower for working age adults with disabilities (51.3%) than those without (75.1%). Among working age people with intellectual disabilities, labour force participation is only 30%.[13]
- ***Violence, abuse and insecurity***[14] – People with disabilities are twice as likely as non-disabled persons to be victims of violence. People with some form of cognitive or mental disability, including intellectual disability, are four times more likely to be victimized than those without. Women with disabilities are sexually assaulted at a rate at least twice that of the general population of women in Canada. Almost two thirds (65%) of violent crimes against persons with activity limitations were committed by someone who was known to the victim. Persons with disabilities are 2 to 3 times more likely to be victims of the most severe forms of spousal violence, including being sexually assaulted, beaten, struck or threatened with a weapon. It is estimated that 80% of psychiatric inpatients have been abused in their lifetimes.[15] Moreover, people with disabilities who are victims of violence are less likely than other victims to be satisfied with the police response and with the ability of courts to deal with the incidents in a timely manner. With the rate of sexual abuse experienced by Aboriginal persons with disabilities at five times the general population,[16] aboriginal persons with disabilities are particularly vulnerable.
- ***Barriers to preventive and acute health care*** – People with intellectual disabilities are three to four times more likely to die preventable deaths because of barriers to needed health care and other supports.[17]

Add to these factors the rapid aging of the Canadian population. This will mean a growing proportion of people with disabilities in the decades ahead and an increasing incidence of financial and other forms of abuse against persons with disabilities including older persons:

- ***Rapid increase in cases of dementia*** – The almost half a million Canadians with dementia in 2008 will increase 2.3 times by 2038 to over 1,125,000 individuals, at which point there will be 250,000 new cases diagnosed each year.[18]
- ***High rates of depression among seniors*** – The Canadian Institute for Health Information reports that over 40% of seniors living in residential care in Canada have either been diagnosed with depression or show symptoms of depression.[19]
- ***Elder abuse*** – Estimates of elder abuse prevalence range from 4-10% of the population, with financial abuse being the leading form.[20]

There is no doubt that conditions of vulnerability affect a large and growing proportion of Canadians with disabilities and older persons. With continued devaluation and discrimination on the basis of disability, and in the absence of needed social and health supports, recourse to physician-assisted suicide and voluntary euthanasia may well become more and more appealing to Canadians. That prospect should profoundly concern us all.

It is imperative that we learn from the historic disadvantage people with disabilities have faced, and also from progressive steps communities and governments are now taking to foster inclusion. These lessons can help inform design of a system to both protect real choice and at the same time safeguard social inclusion for vulnerable persons more generally.

Our Plan has seven main components:

- Core Values
- Principles and Guidelines
- Vulnerability Assessment in Informed Consent
- Advance Independent Review and Authorization
- Monitoring and Public Reporting
- Investment in Palliative Care and Community Supports
- Federal-Provincial/Territorial Jurisdiction, Investment, Coordination and Engagement

1. Core Values

In the opening paragraphs of the *Carter* decision, the Supreme Court of Canada asks how best to "balance competing values of great importance":

> *On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.*[21]

Drawing on *Carter* and earlier decisions by the Court, we discuss below each of these values and point to key challenges and proposals for a system that appropriately balances them.

Autonomy – Freedom from Interference

In *Carter t*he Court states that respect for autonomy guards against "state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering."[22] The court makes clear that "the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision."[23]

Autonomy is a fundamental value in end-of-life decision making. In order to fully respect it, the system for accessing physician-assisted suicide or voluntary euthanasia must ensure that people really making truly self-determined choices. In other words, the system must be designed and managed in a way that ensures lethal interventions are provided only to individuals whose ability to independently choose the intervention has not been compromised in the circumstances.

What will guide the system in making this determination in any particular case? A full understanding of the value of dignity, a second value the Court identifies for guiding a legal framework, is an essential starting point.

Dignity – Valued Recognition of Individuals and Groups

While the Court references 'dignity' many times in the *Carter* decision it does not define the term. However, in a number of other judgments the Court considers the value in some depth and points to the importance of protecting dignity for both individuals and groups. In a comparative analysis of the judicial interpretation of dignity in Canada and internationally, Christopher McCrudden references a number of these decisions. Many point to both individual and group dimensions of dignity.[24] In *Law v. Canada*, for example, the Court defines dignity as follows:

> *Human dignity means that an individual or group feels self-respect and self-worth... Human dignity is harmed when individuals and groups are marginalized, ignored, or devalued, and is enhanced when laws recognize the full place of all individuals and groups within Canadian society.*[25]

In the more recent decision, *R. v. Labaye*, the Court found:

> *Conduct or material that perpetuates negative and demeaning images of humanity is likely to undermine respect for members of the targeted groups and hence to predispose others to act in an antisocial manner towards them. Such conduct may violate formally recognized societal norms, like the equality and dignity of all human beings.*[26]

In *Carter*, the Court emphasizes the impact that denying a choice for assisted suicide can have on an individual's experience of dignity, and quotes the trial judge in this regard: "She [the trial judge] further noted that seriously and irremediably ill persons were 'denied the opportunity to make a choice that may be very important to their sense of dignity and personal integrity' and that is 'consistent with their lifelong values and that reflects their life's experience' (para. 1326)."[27] It is in large part this finding by the Court – that restriction of autonomy can undermine a person's dignity – that leads it to conclude that banning access to physician-assisted suicide and voluntary euthanasia *entirely* cannot be justified.

The individual exercise of autonomy in relation to personal values and experience is one dynamic of dignity. Marginalizing, ignoring and devaluing *whole groups* on the basis of certain shared characteristics is another. In *Eldridge*, the Court gives this latter dimension significant attention with respect to people with disabilities in particular:

> *It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded*

> *from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions... This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the Charter demands.*[28]

There is an extensive literature to support the claim that how social groups are known and recognized in society directly shapes the extent to which members of those groups experience dignity.[29] To the extent that a social group is valued on the basis of shared characteristics, members of that group experience dignity. When a group is devalued on the basis of certain characteristics – like perceived "abnormality or flaw" in the words of the Court in *Eldridge* – members of that group can experience harm to their dignity because of how they are viewed, known and stigmatized by others.

Concern for the ways in which denial of autonomy can undermine dignity is one side of the dignity/autonomy coin and the Court rightly considers it in *Carter*. Concern for the ways in which *harming dignity can undermine autonomy* is the other. How does this happen? The research shows that among the most prevalent reasons for requesting assisted suicide, including an "individual's need for control over the illness and his or her body/life, a desire not to be a burden on others, and depression and psychological distress often associated with illness",[30] disability-related conditions figure prominently. We should be acutely concerned that these reasons predominate in a context, outlined above, of growing prevalence of disability in our society; the enormous scale of depression among seniors living in residential care; the link between mental health-related disability and other types of disability; the lack of needed disability-related support and palliative care; and, the extent of financial and other abuse against people with disabilities.

Given the context of systematic harm to the dignity of persons with disabilities, it is not surprising that individuals with disabilities themselves, along with their family members, health professionals and community members more generally, can come to see their lives as not worthy of living to the same extent as other lives. When others use characteristics similar to one's own as a reason to die or as an indicator of a life not worth living (for example growing physical and cognitive dependence on others which may constitute psychological suffering for some), community support for our unique developmental path can diminish. Valued social recognition and a person's sense of self-worth and self-esteem can be threatened in such an environment and contribute to the vulnerability of persons who live with these characteristics. Indeed, evidence shows how suicidal ideation figures predominantly among people with disabilities both in initial response to onset of disability and in response to lack of access to needed community supports.[31]

For some, the option of accessing physician-assisted suicide or voluntary euthanasia may be appealing because of concern about the financial, emotional and caring burden on a family if a person continues to live for many more months or years to come. This calculus could become more and more compelling, especially as demands on health care and community support services grow. Continuing to live under such circumstances may come to be seen by some as either a selfish act or as an unnecessary drain on publicly-funded health and social supports, and on family caregivers. With these conflicting perspectives already in play, introduction of a system may well sow the seeds for relational harms, making the social environment of a person with a disability that much more vulnerable and both the desire and the decision to continue living that much more untenable.

The Royal Society of Canada's Expert Panel on End-of-Life Decision Making recognized the risk of relational harm, for both individuals and at a "macro" level, which assisted suicide and voluntary euthanasia could engender:

> *Relational harms are very much at issue in cases of assisted suicide and voluntary euthanasia not only at the micro level in terms of the relationships of particular parties (health care professional - patient, between family members, etc.), but also at a macro level in terms of the potential harm to broader social values (respect for autonomy, life, etc.).*[32]

The Panel considered this risk in a context where the interventions remained a violation of the law. However, we are not convinced that individual relationships and broader social values will not be harmed simply because the interventions are legalized. Individual patients, their families, friends and health professionals will be just as torn in the decision-making process, if not more so, when legal access is provided.

To the extent the personal, social and institutional forms of reasoning outlined above become more widespread, they will contribute to and more deeply entrench an already negative social construct of disability. Negative constructs of disability contribute to further disabling people and embedding discrimination because of how they shape social perception. Indeed, the Supreme Court recognized *Mercier* that a "handicap" may result from "a physical limitation, an ailment, a social construct, a perceived limitation or a combination of all of these factors.[33] With the growing scale of cognitive, psychosocial, intellectual and physical disability we see on the horizon, these forms of reasoning risk reproducing negative constructs and social perceptions, further threatening social cohesion and solidarity with these groups.

This is not to suggest that people with disabilities, by definition, are unable to fully exercise autonomy in end-of-life decision making. Such an assumption would perpetuate negative social constructs and systemic devaluation. It is simply to caution that careful consideration must be given in designing safeguards. Protocols must be in place to ensure that a person's dignity has not been so harmed by personal and systemic devaluation and lack of access to needed support that for that person, no other option but physician-assisted death or voluntary euthanasia seems possible. In designing protocols to protect and promote dignity as the basis for autonomy in these circumstances, questions to be addressed include:

- What steps can be taken to ensure that access is carefully considered, and possibly overridden, in those situations the Court states the law should provide for – when people are vulnerable to being induced to commit suicide?
- How can the system assure itself that a person's dignity has not been so undermined by systemic devaluation and lack of access to needed support that his or her exercise of autonomy is too compromised in the circumstances to justify approving a request?
- What steps can be taken to explore alternative courses of action that address devalued status and lack of supports, and when and how is that exploration process triggered?
- How can the system contribute to a culture that promotes social inclusion, solidarity and cohesion that makes living with disability something to be valued in society, rather than in any way denigrated?

To answer these questions it is helpful to draw on the third value that the Court states should be balanced in regulating access to physician-assisted suicide and voluntary euthanasia – the sanctity and preservation of life.[34] The Court finds that this value underlies the valid objective of the prohibition, to protect vulnerable persons from being induced to commit suicide.

Inclusion – Community Support, Access and Participation

In the course of a lifetime most of us build up a personal supply of assets which provide resilience to vulnerability and that keep us safe, barring unforeseen circumstances. However, this is often not the case for individuals who experience systemic disadvantage.[35] Assets that help reduce vulnerability are also indicators of inclusion:

- having a job or other income;
- having an education;
- having a safe and comfortable place to live;
- having the supports that we need;
- having family and friends who care about us;
- being valued and respected in our communities.

We suggest that protecting and preserving sanctity of life of vulnerable persons in the context of a system for physician-assisted suicide and voluntary euthanasia should be understood as safeguarding the value of inclusion. Through a series of cases decided under the *Charter of Rights and Freedoms* the Supreme Court of Canada has evolved an understanding of equality as full inclusion in society.[36] Central to the Court's understanding is the importance of full participation in, and meaningful and equal access to education, the workforce, transportation and other services.[37] When people with disabilities are included in society in this manner, the conditions of their vulnerability are ameliorated. In this regard, the Law Commission of Ontario defines the principle of 'social inclusion and participation' as it applies to persons with disabilities as follows:

> *This principle refers to designing society in a way that promotes the ability of all persons with disabilities to be actively involved with their community by removing physical, social, attitudinal and systemic barriers to exercising the incidents of such citizenship and by facilitating the involvement of persons with disabilities.*[38]

Research on vulnerability suggests that it is not only the lack of access, support and participation that makes people with disabilities vulnerable. It is often the dependent position people are placed in, in relation to their support providers. ARCH Disability Law Centre reports on how this dynamic can threaten the status of persons with disabilities:

> *[t]his dependence leaves people with disabilities vulnerable; they must work hard to maintain good relationships with support workers, family members and others on whom they rely in order to ensure that they continue to receive support and their basic needs are met. Making a complaint about a support worker or raising a concern about services may threaten or sever those relationships, and this can have disastrous impacts for the person with a disability.*[39]

Inquiry into the conditions of vulnerability and consideration of alternative courses of action that would maximize inclusion will be necessary in some cases to determine if the request is in fact an autonomous choice that respects and promotes a person's dignity. The principle of autonomy as freedom from interference must certainly be protected in the system. At the same time, given what is at stake for a person and for society in ensuring that vulnerable persons are indeed protected, a role for state intervention is justifiable when it appears that vulnerable persons may not be able to fully exercise autonomy in making a request or are being induced to make the request.

Legal scholar, Martha Albertson Fineman, suggests that the existence of vulnerability provides a clear foundation for state intervention and oversight to address its conditions:

> *The nature of human vulnerability forms the basis for a claim that the state must be more responsive to that vulnerability. It fulfills that responsibility primarily through the establishment and support of societal institutions. Additionally, those institutions are themselves vulnerable to a variety of internal and external corruptions and disruptions, and this realization is the basis for the further claim that these institutions must be actively monitored by the state in processes that are both transparent and inclusive.*[40]

2. Principles and Guidelines

The pillars of our proposed system are outlined in the following principles and guidelines.

Fundamental Principles

1. Real autonomy in choosing physician-assisted suicide and voluntary euthanasia must include consideration of alternative courses of action.

2. People are made vulnerable as a result of social or economic circumstances that diminish their resiliency. Conditions such as poverty, isolation, discrimination, devaluation and lack of needed supports are therefore highly relevant in determining whether a person may be vulnerable to inducement.

3. Persons who are vulnerable to being induced to commit suicide in times of weakness must be protected, their conditions of vulnerability anticipated and adequately responded to.

4. Persons with disabilities and their representative organizations have much at stake in the design, delivery and evaluation of any system developed to protect persons who are vulnerable to being induced to request physician-assisted suicide and voluntary euthanasia.

Guidelines for Legislative and Policy Response

1. Assisted suicide must be available only to adults who are able to act legally independently and with a grievous and irremediable condition that is the cause of enduring suffering that is intolerable to the individual. 'Legal independence' for the purposes of health care, property and personal decisions has been defined as a person's ability "by him or herself or with assistance, to understand information that is relevant to making a decision; and... the ability, by him or herself or with assistance, to appreciate the reasonably foreseeable consequences of a decision.41
2. In and of itself, disability is not a grievous and irremediable condition.
3. Requests for physician-assisted suicide and voluntary euthanasia must be reviewed and authorized by an independent review panel, with sufficient information to determine if the necessary criteria are met. This review must occur prior to any approved actions causing a person's death.
4. In making its decision the review panel must consider the following information:
    a. The person's request and reasons for the request;
    b. A clinical evaluation by a qualified physician regarding whether the person meets the medical criteria;
    c. A clinical evaluation by a qualified physician regarding whether the person's condition is irremediable in the sense that it is likely to cause death within the foreseeable future. Where this prognosis is not the case, special inquiry must be made into whether there are conditions that place the person at risk of being vulnerable to being induced to commit suicide, and whether all alternative courses of action have been considered.

   d. An evaluation by a qualified physician that the person is competent to make the decision;
   e. An assessment of whether the person's request is informed and voluntary;
   f. An assessment of potential alternative courses of action that might reduce the person's suffering. This assessment must be conducted by a qualified professional in consultation with the patient, and must address a full range of alternatives to physician-assisted suicide and voluntary euthanasia including medical treatment, palliative care, counselling and disability related supports.
   g. Submissions by third parties with direct knowledge relevant to the request, subject to the discretion of the review panel;
   h. The length of an appropriate waiting period in the circumstances to ensure the person has adequate time to consider alternative courses of action, as may be needed;
   i. Any need for an expedited process to ensure compassion can be exercised where criteria are clearly met and death is imminent or in the near future;
5. Clinical input to the review panel must come from at least two different physicians.
6. A monitoring system and annual public reports to Parliament and provincial/territorial legislatures must be in place to track and report on:
   a. the number of requests;
   b. the reasons given;
   c. medical condition, socio-economic circumstances and demographic factors associated with persons making requests, and those whose requests are authorized or denied;
   d. availability and acceptance or refusal of alternative courses of action identified;
   e. efficacy of alternative interventions including access to medical treatment and palliative care;
   f. outcome of requests authorized and denied.

These principles and guidelines are designed to help legislators, policy makers and regulators achieve the right balance between dignity, autonomy and inclusion. They are informed by an inclusive vision of ethics and law and are designed to ensure that real choice is made available to persons considering physician-assisted suicide and voluntary euthanasia. By definition, real choice in this case must include consideration of alternative courses of action to the intervention.

Advance independent review and authorization of the decision is also an essential mechanism for ensuring real choices are provided so that autonomy can in fact be exercised. This will help to ensure that the foundations of inclusion – equal respect and support for different developmental pathways, including those identified as disabled – are fostered and remain intact. Finally, the guidelines point to a need for monitoring and public reporting to ensure transparency and guide ongoing evaluation and adaptation of the system as may be needed to ensure compliance with underlying values, principles and guidelines.

Distinguishing Physician-assisted Suicide and Voluntary Euthanasia from Palliative Care

Our proposal is also based on clearly distinguishing physician-assisted suicide and voluntary euthanasia from palliative care. We strongly urge that physician-assisted suicide and voluntary euthanasia not be considered one of the options in a palliative care system. We also urge that patients who are receiving palliative care and decide to choose physician-assisted suicide or voluntary euthanasia are not abandoned by the palliative system. Obligations must be in place to ensure that patient autonomy is respected, while at the same time not requiring health care providers to fundamentally alter their provision of services.

Distinguishing physician-assisted suicide and voluntary euthanasia from palliative care rests on the difference between intent and foresight, as legal scholar John Keown has forcefully argued in his systematic critique[42] of the reasoning in the *Carter* decision handed down by Justice Lynn Smith of the British Columbia Supreme Court.[43] While administration of pain management may be done in palliative care, for example, with the foresight that death will eventually come, death is not the intent of the intervention. In physician-assisted suicide and voluntary euthanasia, on the other hand, bringing about death is the intention and a chemical regime is administered for this purpose. We strongly recommend that in order to protect the ethics and integrity of palliative care that these distinctions remain in clear view.

3. Vulnerability Assessment in Informed Consent

Assessing Vulnerability

The Supreme Court stresses numerous times in the *Carter* judgment that a system for access to physician-assisted suicide and voluntary euthanasia must include measures to protect vulnerable persons from being induced to commit suicide in a time of weakness. When the causes of people's suffering are discrimination, being devalued by others, lack of support or social isolation, steps can be taken to address them. As well, when people are disabled as a result of traumatic injury or illness, suicidal thoughts often come in early stages of recovery and/or care.

The system for physician-assisted suicide and voluntary euthanasia must be sensitive to these risks and include mechanisms to assess their impact on autonomous choice. Therefore, it must be structured to identify and assess possible vulnerability factors and facilitate exploration of, and access to, appropriate supports for people who request assistance to die. Factors to address in a vulnerability assessment should include:

- Poverty and lack of needed care and support;
- Social isolation;
- A sense of being a burden on others;
- Experience of growing dependence on others and a loss of control;

- Denial of rights or social stigma which leads to experience of disrespect and devaluation;
- Abuse and intimidation by others who stand to financially or otherwise benefit from the person's death;
- Encouragement from others that promise that true dignity and nobility will come as a result of their choice of death.

We recommend mandatory application of a 'vulnerability lens' at three points, namely: where a person makes a request for physician-assisted suicide and voluntary euthanasia; during the process of considering alternatives; and, at the stage of advance independent review and authorization. This is necessary to ensure that potentially vulnerable people are identified and safeguarded by the system, as required under the law. As required under the *Carter* decision, where significant vulnerability to inducement is identified, physician-assisted suicide or voluntary euthanasia cannot be the first recourse, even if requested. Alternative courses of action must be facilitated.

However, the system should not require detailed assessment of vulnerability when it is clear that a person meets the criteria as laid out in *Carter*, death is imminent or foreseeable in the near future, suffering is enduring and intolerable and the decision is clearly informed and voluntary. Compassion is paramount in these situations and the system should be designed to ensure that the decisions can be expedited and carried out after any appropriate waiting period.

Informed Consent Process

Given the widespread conditions of vulnerability among Canadians with disabilities and older persons, and given the gravity of the decision under consideration, a process for exploring alternative courses of action to physician-assisted suicide and voluntary euthanasia, including palliative care, must be provided for in the consent process.

Exploring alternative courses of action is a well-established and legally-recognized step in the informed consent process. For example, Ontario's *Health Care Consent Act* stipulates in s.11(2) that "A consent to treatment is informed if, before giving it, the person received the information about the matters set out…" which include information about "alternative courses of action."[44]

It is important to recognize that exploring alternatives to the social and economic conditions of vulnerability which place people at risk of being induced to commit suicide in times of weakness is likely beyond the capacity of family or specialist physicians. Many alternative courses of action in relation to standard health care decisions are within the scope of a physician's expertise, including palliative care and pain management. However, considerations of psychological suffering, vulnerability and inducement are not usually part of their expertise or training so it is appropriate that these be explored by a professional with more knowledge and training in these non-medical considerations.

As well, it is important to note that considerations of coercion, undue influence, pressure and exploitation of inequality particularly in the context of intimate and confidential relationships, are not usually considered in health care decisions. However, precedent exists for consideration of these factors, along with decisional capacity, in other areas of law, for example, testamentary capacity in relation to the making of wills.[45] The informed consent process for physician-assisted suicide and voluntary euthanasia must be adapted to ensure these factors are adequately considered, and that any vulnerability to inducement can be ruled out.

Given these considerations, gathering information about possible undue influence and suspicious circumstances, and any alternatives in the person's family and community social support system, will require assistance of qualified assessors. We recommend the following approach be taken to ensure truly informed consent is obtained, as required by law:

- Alternative course of action be assessed by a qualified assessor in every case where a request for physician-assisted suicide and voluntary euthanasia is made to a responsible physician, and where the physician makes an initial determination that person making the request has the decisional capacity to act legally independently;
- Qualified assessor explores alternatives with the patient and ensures the patient is aware of options, and assisted to pursue any chosen options;
- Qualified assessor sends report to responsible physician and independent review board;
- If, after the assessment, the patient continues to request physician-assisted suicide and voluntary euthanasia, the responsible physician ensures that the patient is giving 'informed consent' and has the decisional capacity to do so;
- Referral is then made for consideration by an independent review.

Without proactive measures and a process for considering a range of alternative courses of action, real choice and informed consent are simply not possible for many people with disabilities. To be given the option for physician-assisted death or voluntary euthanasia without such consideration would be inconsistent with law, discriminatory and would demonstrate a lack of compassion. It would represent the denial of the life, liberty and security of the person. The process must provide full scope for identifying vulnerability and providing alternatives.

We recognize there will be a small number of extremely difficult situations where individuals are experiencing suffering of such an extent that they make a request for physician-assisted suicide and voluntary euthanasia where alternatives are either extremely limited or do not exist at all. To require a person to undergo extensive vulnerability assessment in these circumstances would neither be compassionate or respectful of their autonomy and dignity. In such situations, any assessments must be sensitive to the timeliness required, the suffering involved and a reasonable scope of options in the circumstances.

Determining Decisional Capacity

The Supreme Court emphasizes that one of the criteria to obtain physician-assisted suicide and voluntary euthanasia is that the person be a competent adult, which it states means having decisional capacity as can usually be determined by a physician. There is a growing recognition, however, that determining decisional capacity is not a straightforward matter, especially with the growing proportion of older persons in the population and often associated cognitive decline. As well, the United Nations *Convention on the Rights of Persons with Disabilities*, ratified by Canada in 2010, has a bearing on an emerging understanding of 'supported decision making' capacity. It recognizes in Article 12 that persons cannot be discriminated against in the exercise of legal capacity, on the basis of mental or physical disability, including for health-related decisions, and that state parties have an obligation to ensure people have access to the supports they may require to exercise their decisional capacity.

All of this means that it may be impossible to draw a 'bright line' between those who have capacity to make the decision to have physician-assisted suicide and voluntary euthanasia, and those who do not. This makes it especially important to ensure that persons are free of vulnerability to inducement in making this life-ending decision.

While jurisprudence on decisional capacity and competence points increasingly to the legal obligation to recognize supports in decision making, we propose that a legislative line be clearly drawn. A report for the Law Commission of Ontario recommends that for the purposes of decisions that may fundamentally affect a person's mental or physical integrity, of which physician-assisted suicide and voluntary euthanasia is one, the law require that the person be able to act 'legally independently' (as defined in the proposed Guidelines above). That is, a person *on his or her own* must be able to fully understand and appreciate the nature and consequences of the decision, with supports and accommodations as may be required for this purpose.[46]

The report also recommends that health care and decision-making statutory law provide for identifying decisions which must be made *exclusively* in this manner, and which we would recommend must also include physician-assisted suicide and voluntary euthanasia. This would mean that persons who require extensive supports to make decisions, and who thus do not meet the test of legal independence, could not be considered to have the decisional capacity to consent to physician-assisted suicide or voluntary euthanasia.

4. Advance Independent Review and Authorization

The need for independent review and oversight in physician-assisted suicide and voluntary euthanasia has been recognized in international law to be an essential safeguard in ensuring respect for the inherent right to life. More than once, the United Nations Human Rights

Committee has called on the Netherlands, where physician-assisted suicide is recognized in law and can be authorized by two physicians, to provide for independent review in order to "guarantee that this decision was not the subject of undue influence or misapprehension."[47] The Committee justifies the need for "independent review by a judge or magistrate" because of the potential for violation of the "inherent right to life" as recognized in Article 6 of the *International Covenant on Civil and Political Rights*, ratified by Canada in 1976.

Our proposal is for *advance* independent review and authorization of requests for physician-assisted suicide and voluntary euthanasia, along with an appropriate waiting period. We believe this is the only way to ensure that the decision is, in fact, 'not the subject of undue influence or misapprehension.' This must be combined with an appropriate waiting period after the initial request is made, in order to ensure there is opportunity to re-consider the request and any alternative courses of action that may be identified in the interval.

Without advance independent review and an appropriate waiting period, the risk of vulnerability to inducement cannot be adequately assessed. Advance information required should include: the reasons given for the request, the medical condition, socio-economic circumstances, demographic factors, decisional capacity, results of the vulnerability assessment, and information on availability and acceptance or refusal of alternative courses of action identified, including palliative care. Efficacy of alternative interventions in withdrawing requests should also be reported.

The 'check and balance' of an advance independent review and authorization has a number of positive features:

- Ensures that adequate assessment about vulnerability and alternative courses of action has been undertaken;
- Takes any equivocation about whether to authorize or report a physician-assisted suicide and voluntary euthanasia out of the hands of physicians, and thereby addresses the well-documented issue of physicians not reporting assisted deaths,[48] evident in all jurisdictions with systems now in place;
- Ensures that trusted family physicians are not placed in the position of authorizing interventions intended to cause death, although they may be asked to carry out that intervention and may choose to do so once authorized;
- Ensures that the principles of dignity, autonomy and inclusion are applied in every single case, and that potential for relational harm is considered;
- Provides for an expedited process where warranted;
- Helps protect against loosening the interpretation of the Court's criteria for eligibility that could come in practice without such oversight, and thereby deters from the slippage now being seen in other jurisdictions.[49]

It is simply not possible for one physician or two physicians to manage these needed checks and balances. Physicians should determine capacity to decide and, with the help of a qualified assessor, determine whether there is evidence of vulnerability to being induced to commit suicide. An advance independent review and authorization body can assess this evidence and also determine whether the inherent right to life has been adequately protected in the circumstances in order to maximize social inclusion.

This 'division of labour' and system of checks and balances would help build trust in the system, assuring that where reasons for physician-assisted suicide and voluntary euthanasia seem suspect, or where they are rooted in negative stereotypes and stigma about a life presumed not worth living, that pause in the decision-making process could be afforded. Additional evidence could be called for, and a deeper assessment of vulnerability could be undertaken if required

Some have suggested that the safeguards in jurisdictions which have implemented physician-assisted suicide and voluntary euthanasia, largely consisting of review and approval by two physicians, are sufficient. Margaret Battin, et al., for example, suggest that such systems are adequate to protect the vulnerable and avoid abuse, although the authors indicate that the evidence is not conclusive. Moreover, they arrive at their assessment on the basis that fewer elderly persons, for example, chose assisted death than those in the 18-64 range, fewer women than men, fewer of those with lower socio-economic status than higher, etc. While these may be standard categories of vulnerability, the data tell us nothing about whether people who chose physician-assisted suicide and voluntary euthanasia experienced the vulnerability that comes with a sense of losing independence, diminishing capacity, feeling a burden on others, or social isolation. In fact, the evidence shows substantial increase in physician-assisted suicide and voluntary euthanasia in jurisdictions where it has been legalized (an increase in Belgium, for example, of over 550% between 2002 and 2009),[50] and authorized precisely for these kinds of reasons, underlying which are often negative stereotypes based on disability.

In the interests of compassion, we again want to stress that the process of advance independent review and authorization should not be onerous where it is not warranted. As with the process for assessing vulnerability outlined above, the review should be extremely sensitive and adaptive to the need for timely decisions. There should be provision for an expedited process where a person has made a clear request, provided informed consent, extensive vulnerability assessment and consideration of alternatives is obviously redundant, death is imminent or near and suffering is enduring and intolerable in the circumstances. Experience with independent review mechanisms such as the Ontario Consent and Capacity Board demonstrate that such mechanisms can render very timely decisions as may be needed.

5. Independent Monitoring and Public Reporting

A monitoring system and annual public reports to Parliament and provincial/territorial legislatures is essential for an effective system for regulating access to physician-assisted suicide and voluntary euthanasia. Ultimately, legislative bodies must be able to determine if the parameters of the safeguarding system are sufficient to protect the right to life and inclusion, while respecting real choice and the principle of dignity for all persons and groups.

In order to deliberate on this question, policy makers and legislatures must have reliable information on the functioning of the system. Independent bodies to provide advance review and authorization can facilitate valid and reliable information sources for monitoring purposes. In addition to the information provided as part of the requests, physicians administering approved physician-assisted suicide or voluntary euthanasia should also be required to report to the independent bodies on the time and outcome of the administration, any variance in decisions once authorized, and confirmation that informed consent was obtained. With all this information, the independent bodies will be able to report on requests made, those authorized and denied, and the outcome of those requests in either case.

A federal authority should be established to work with provincial/territorial governments in developing consistent protocols for gathering information. Independent review bodies in each province and territory should be charged with annual reporting to their respective legislatures, and the federal authority should also report annually to Parliament with a national picture based on this information.

6. Needed Investment in Palliative Care, Disability and Community Supports

As noted, there are well-documented gaps in access to palliative care, with estimates that 70% of Canadians are not able to access care they need.[51] As the Quality End-of-Life Care Coalition of Canada notes, this will become a growing issue with the expected deaths per year in Canada to increase from the current approximately 260,000 deaths per year to more than 425,000 per year by 2036.[52] As the Coalition also indicates: "Despite the fact that most Canadians would prefer to die at home, surrounded by their loved ones, most are still dying in hospitals or long-term care homes."[53]

At the same time, there is an extensive gap in needed disability supports affecting both people with disabilities and families, with Statistics Canada reporting unmet needs for help for 49% of people with severe disabilities, and 80% of those not living on their own relying on families for care.[54]

With rapid aging of the population and increase in disability prevalence, entrenched poverty of people with disabilities, the hugely disproportionate rates of violent victimization and abuse of persons with disabilities, and the growing gap in need for palliative care and disability-related supports, the stage is set for social vulnerability to grow exponentially over the next few decades. It is in the context of a federal-provincial/territorial policy vacuum to meet the current and anticipated scale of need and a completely inadequate patchwork system of community supports that requests and support for physician-assisted suicide and voluntary euthanasia has grown in the past twenty years. Without needed investments and safeguards, they will grow substantially in years to come.

We must make certain that physician-assisted suicide and voluntary euthanasia in Canada does not become a choice of individuals and families by default: the only way to re-gain some sense of control over one's life and end the sense of burden on others that result from a lack of other options. This is not a calculus Canadians should be forced to make.

Governments must step up to ensure that Canadians have real choice and alternative courses of action, even in situations of irremediable medical conditions and the experience of profound suffering. We believe there can *always* be alternatives – not that individuals should be forced to choose them – provided we make the political, fiscal and policy decisions to make them available.

7. Federal-Provincial-Territorial Jurisdiction, Investment, Coordination and Engagement

A system for regulating physician-assisted suicide and voluntary euthanasia in Canada should be established through a coordinated federal-provincial/territorial framework. Both levels of government have roles to play. We propose broad outlines for the roles of each level of government below.

Criminal Code Amendments

In order to balance the principles of dignity, autonomy and inclusion, the Supreme Court determined that the ban on assisted suicide must remain in place in the *Criminal Code* in order to protect persons who are vulnerable to being induced to commit suicide. As such, amendments to the *Criminal Code* are required to ensure clear and consistent standards across the country, with clear parameters for criminal violation. Provisions in the *Code* should address: eligibility criteria for access; the requirements for legal independence in informed consent; requirement of vulnerability assessments; the waiting period; and the mechanism for advance independent review and authorization of requests.

We strongly support the recommendations for *Criminal Code* amendments in this regard as proposed by David Baker and Gilbert Sharpe,[55] and also the recommendations of the Royal Society of Canada Expert Panel of End-of-Life Decision Making, which states:

> *The Criminal Code is the best available mechanism for legal reform for a number of reasons. First, as it flows from the federal Parliament, it provides for the greatest consistency of approach across all of the provinces and territories. There is merit in treating an issue of such extraordinary social significance grounded in constitutional values as consistently across the country as possible. Second, again, as it flows from the federal Parliament, it allows for the creation of a national oversight body that could ensure an accurate and comprehensive picture of what is happening in the area of assisted suicide and voluntary euthanasia across the country. This would be efficient, protective, and reassuring as well as in line with best international practice.*[56]

Criminal Code requirements for an independent body for advance review, authorization and monitoring at the provincial/territorial level could be modeled on, or be an expanded version of, the provincial/territorial Review Boards currently required under the *Code*. Alternatively, the *Criminal Code* could set out requirements for such authorities and provincial/territorial governments could establish or adapt such administrative boards as currently exist, for example the Consent and Capacity Board in Ontario.

Provincial/Territorial Regulation of Informed Consent, Vulnerability Assessment and Health Professions

The legislative, policy and program framework for informed consent, vulnerability assessments, and procedural requirements for advance independent review and authorization must also be recognized and regulated by statute in provincial/territorial jurisdictions. A regulatory framework for health professions and the delivery system for acute and community-based health services, mental health care and palliative care will need to be established in order to ensure appropriate delivery, consistent with *Criminal Code* requirements. Associated law reform in health care, informed consent, adult protection and legal capacity will be required in order to protect real choice and autonomy and to safeguard social inclusion for vulnerable persons.

Coordinated Investment Strategy

There is real risk that physician-assisted suicide and voluntary euthanasia will become policy choice by default, and attractive to both individuals and governments because of collective failure to adequately invest in needed health and social supports and palliative care. We urge federal and provincial-territorial governments to guard against this outcome, and to take early and coordinated preventive action. Both levels of government must come up with the fiscal mechanisms to ensure adequate and coordinated investment, and shared guidelines for policy and program development associated with that investment.

Government-Community Engagement

We also urge the federal and provincial/territorial governments to establish a coordinated process to guide development, implementation and monitoring of the system and the investment strategy for health and social supports and palliative care. The first priority should be developing draft legislation and policy for both levels of government. A standing federal-provincial/territorial table should be established for this purpose. It should bring together officials from relevant departments of justice and health and social services, and proactively engage representatives of health professions, and the disability and older person communities.

Conclusion

The Supreme Court of Canada has placed Canadian society at a crossroads. Despite extremely polarized views on the morality, ethics and law of physician-assisted suicide and voluntary euthanasia, Canada will go down this path effective February 6, 2016 or shortly thereafter.

Physician-assisted suicide or voluntary euthanasia is a final and irreversible intervention for a person, a family, loved ones, those administering the intervention with the intent to cause death, and the community as a whole. We must make certain that in every case, real autonomy is being exercised by individuals, in a context of assured dignity, access to needed supports for palliative care or for continuing to live in the community, information about alternative courses of action where available, and informed consent.

We must also make sure that protocols are in place to address the situations where a person's dignity has been systemically harmed because of devaluation on the basis of disability, social exclusion and lack of access to needed supports. It is when people lack needed support and a sense of dignity in relation to others that they can come to feel like a burden, experience social isolation and thus lose a sense of autonomy over their own lives. In this context, choice for assisted suicide may not always be entirely self-determined. The demographic overview provided raises extremely serious concerns about introducing a system for physician-assisted death in a context of the rapidly growing population of Canadians with a disability and their systematic disadvantage, devaluation and victimization.

In this context, we must design the system to ensure that as people gain access to physician-assisted suicide and voluntary euthanasia, on the basis of protecting their autonomy and dignity, this does not undermine or diminish equal community respect and solidarity with others who continue to live and seek to thrive with similar medical conditions or disability.

In order to ensure that Canadians can find some common ground on which to build a system, we urge that key actors and stakeholders keep in view the interdependent values of autonomy, dignity *and* inclusion. Collectively abiding by these values and associated principles and guidelines will help build necessary bridges and address legitimate concerns. We fundamentally believe this requires a system for regulating access to physician-assisted suicide and voluntary euthanasia that has as its main pillars: vulnerability assessment; advance independent review and authorization; monitoring and public reporting to Parliament and provincial/territorial legislatures; and a coordinated engagement and investment strategy. Without these pillars firmly in place, the Supreme Court of Canada's requirement that the system must protect persons who may be vulnerable to inducement to commit suicide cannot be met.

Developing and implementing a system for regulating physician-assisted suicide and voluntary euthanasia must be a coordinated legislative, policy and program development priority. Both levels of government have a duty to legislate, invest and regulate. We must avoid at all costs uneven and risky developments across the country. For this purpose, and in addition to embedding the requirements of the system in the *Criminal Code,* a joint federal-provincial/territorial government and community table must be established. It should be mandated to develop a shared framework for: regulating access to physician-assisted suicide and voluntary euthanasia; investing in palliative care and disability supports; guiding and monitoring implementation; and recommending and negotiating changes to the system as needed.

The disability community in Canada has been profoundly affected by the *Carter* judgment because of the risk we believe it poses to advancing inclusion, equality and human rights for Canadians with disabilities. We hope the proposals presented here are taken in the spirit and with the purpose for which they were developed: that of finding common ground in the design of a system for physician-assisted suicide and voluntary euthanasia in Canada that protects real choice and safeguards inclusion. We urge that foresight, caution, compassion and core values guide us all in the exercise ahead so that the system will contribute to, rather than undermine, autonomy, dignity and inclusion for all Canadians throughout their lifetimes.

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Endnotes

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[1] *Carter v. Canada (Attorney General),* 2015 SCC 5.

[2] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 125.

[3] The Royal Society of Canada Expert Panel (November 2011). *End-of-Life Decision Making*. Ottawa: Royal Society of Canada, at p. 7.

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[5] Douglas Durst (2006). Urban First Nations People with Disabilities Speak Out. *Journal of Aboriginal Health* (September 2006).

[6] For a comparison of 2001 and 2006 disability rates in these population groups, see Statistics Canada, *Participation and Activity Limitation Survey: Analytical Report* (Ottawa: Statistics Canada, 2007), online: http://www.statcan.gc.ca/pub/89-628-x/89-628-x2007002-eng.htm (last accessed: 24 September 2014).

[7] Rubab Arim (2015). *A profile of persons with disabilities among Canadians aged 15 years or older, 2012*. Ottawa: Statistics Canada.

[8] The Honourable Sharon Carstairs (2010). *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*. Ottawa: Senate of Canada, at p. 24.

[9] Quality End-of-Life Care Coalition of Canada (2010). Blueprint for Action: 2010 to 2020. Ottawa: Author, at p. 1.

[10] P. Smetanin, D. Stiff, C. Briante, C.E. Adair, S. Ahmad and M. Khan (2011). *The Life and Economic Impact of Major Mental Illnesses in Canada: 2011 to 2041*. Toronto: RiskAnalytica, on behalf of the Mental Health Commission of Canada.

[11] See Samuel Perrault (2009). *Criminal victimization and health: A profile of victimization among persons with activity limitations and other health problems*. Ottawa: Statistics Canada.

[12] Christine Bizier, Carley Marshall and Gail Fawcett (2014). *Mental health-related disabilities among Canadians aged 15 years and older, 2012*. Ottawa: Statistics Canada.

[13] Cameron Crawford (2013). Looking Into Poverty: Income Sources of Poor People with Disabilities in Canada. Toronto: IRIS - Institute for Research and Development on Inclusion and Society, 2013. Online: http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/demographic-profile/income-sources-of-poor-people-with-disabilities; Crawford, C. (2013 version). *Disabling Poverty & Enabling Citizenship: Understanding the Poverty and Exclusion of Canadians with Disabilities*. Winnipeg: Council of Canadians with Disabilities. Online: http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/demographic-profile/understanding-poverty-exclusion.

[14] For statistics referenced in this section, see Samuel Perrault (2009). *Criminal victimization and health: A profile of victimization among persons with activity limitations and other health problems.* Ottawa: Statistics Canada.

[15] National Clearing House on Family Violence (2004). Violence Against Women with Disabilities. Ottawa: Minister of Public Works and Government Services Canada.

[16] Larry Chartrand and Celeste McKay (2006). *A Review of Research on Criminal Victimization and First Nations, Métis and Inuit Peoples 1990-2001.* (Ottawa: Department of Justice Canada).

[17] See P. Heslop et al (2014) The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. *The Lancet*; 383: 9920, 889–895; and Stacey Atkinson, Joanne Lay, Su McAnelly, Malcolm Richardson (eds.) (2015), *Intellectual Disability in Health and Social Care*. New York: Routledge.

[18] P. Smetanin, P. Kobak, C. Briante, D. Stiff, G. Sherman, G. and S. Ahmad, *Rising Tide: The Impact of Dementia in Canada 2008 to 2038.* Toronto: Alzheimer Society Canada.

[19] Canadian Institute for Health Information (2010). *Depression among Seniors in Residential Care: An Analysis in Brief.* Ottawa: Author.

[20] See, for example, E. Podnieks (2008), Elder abuse: the Canadian experience. *Journal of Elder Abuse and Neglect*, 20(2):126-50; Charmaine Spencer (1998). *Diminishing Returns: An Examination of Financial Abuse of Older Adults in British Columbia.* Vancouver: Gerontology Research Centre, Simon Fraser University.

[21] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 2.

[22] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 67.

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[23] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 67.

[24] Christopher McCrudden (2008). Human Dignity and Judicial Interpretation of Human Rights. *The European Journal of International Law* Vol. 19 no. 4.

[25] *Law* v. *Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 53.

[26] *R. v. Labaye,* 2005 SCC 80 at para. 46.

[27] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 65.

[28] *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 at para. 59.

[29] A seminal essay by Canadian philosopher, Charles Taylor, launched a rich literature on how social recognition of one's group characteristics shape one's experience of dignity. See Charles Taylor (1994). The Politics of Recognition. *Multiculturalism: Examining the Politics of Recognition.* Ed. Amy Gutmann. Princeton: Princeton University Press, pp. 25-73. In a series of more recent studies, Axel Honneth has examined the inter-relationship between valued recognition of one's group status, and the experience of dignity. See, for example, Axel Honneth (2012). *The I in We: Studies in the Theory of Recognition*. Cambridge: Polity Press.

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[31] Tom Shakespeare (2006). *Disability Rights and Wrongs*. Abingdon: Routledge, p. 129.

[32] The Royal Society of Canada Expert Panel (November 2011). *End-of-Life Decision Making*. Ottawa: Royal Society of Canada, p. 99.

[33] *Québec (Commission des droits de la personne & des droits de la jeunesse) v. Montréal (City)*, 2000 SCC 27, [2000] 1 S.C.R. 665, [2000] S.C.J. No. 24 at para. 79 [*Mercier*].

[34] *Carter v. Canada (Attorney General),* 2015 SCC 5 at para 77.

[35] See, for example, Peadar Kirby (2006), *Vulnerability and Violence: The Impact of Globalisation*. London: Pluto Press.

[36] Jo-Ann Pickel (2007). Supreme Court of Canada Grapples with the Social Construction of Disability: Council of Canadians with Disabilities v. Via Rail. Online: http://www.cavalluzzo.com/resources/publications/details/supreme-court-of-canada-grapples-with-the-social-construction-of-disability-council-of-canadians-with-disabilities-v.-via-rail.

[37] For a discussion of these themes in the Supreme Court of Canada's jurisprudence see, for example, Yvonne Peters and Debra Parkes (2014). Making Poverty a Human Rights issue for People with Disabilities. Online: http://ccdonline.ca/en/socialpolicy/poverty-citizenship/legal-protections/making-poverty-a-human-rights-issue-for-people-with-disabilities; and Judith Mosoff (2009). Lost In Translation? The Disability Perspective In Honda V. Keays and Hydro-Québec V. Syndicat. *McGill Journal of Law and Health*, Vol. 3.

[38] Law Commission of Ontario (2012). *A Framework for the Law as it Affects Persons with Disabilities*. Toronto: Author, p. 82.

[39] Kerri Joffe (ARCH Disability Law Centre), 2010. Enforcing the Rights of Persons with Disabilities in Ontario's Development Services System. Toronto: Law Commission of Ontario. Online: http://www.lco-cdo.org/en/disabilities-call-for-papers [Joffe], p. 31.

[40] Martha Albertson Fineman (2010-2011), The Vulnerable Subject and the Responsive State, *60 Emory L.J. 251,* pp. 255-256.

[41] See Michael Bach and Lana Kerzner (2010), A New Paradigm for Protecting Autonomy and the Right to Self-Determination. Toronto: Law Commission of Ontario. Online: http://www.lco-cdo.org/disabilities/bach-kerzner.pdf, p. 84. This formulation is similar to the definition of capacity in the Northwest Territories' *Guardianship and Trusteeship Act*, S.N.W.T., 1994, c.29, s.12(1).

[42] John Keown (2014), A Right to Voluntary Euthanasia? Confusion in Canada in Carter. *Notre Dame Journal of Law, Ethics & Public Policy*, 28:1, at pp. 4-17.

[43] Carter v. Canada (Att'y General), [2012] B.C.S.C. 886 (Can. B.C.). This judgment was largely drawn upon and supported by the Supreme Court of Canada in its ruling in the Carter appeal.

[44] *Health Care Consent Act*, 1996, S.O. 1996, c. 2 s. 11(3)5.

[45] See, for example, discussion of 'undue influence' and 'suspicious circumstances' in British Columbia Law Institute (2013), *Report on Common-Law Tests of Capacity*. Vancouver: Author.

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[46] See Michael Bach and Lana Kerzner (2010), A New Paradigm for Protecting Autonomy and the Right to Self-Determination. Toronto: Law Commission of Ontario. Online: http://www.lco-cdo.org/disabilities/bach-kerzner.pdf.

[47] U.N. Human Rights Committee, *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant*, para. 7, U.N. DOC. CCPR/C/NLD/CO/4 (Aug. 25, 2009). *See also* U.N. Human Rights Committee, *Concluding Observations of the Human Rights Committee: Netherlands*, para. 5–6, U.N. DOC. CCPR/CO/72/NET (Aug. 27, 2001).

[48] For an overview of this research and a critique of the evidence relied upon in *Carter* to determine adequacy of safeguards, see John Keown (2014), A Right to Voluntary Euthanasia? Confusion in Canada in Carter. *Notre Dame Journal of Law, Ethics & Public Policy*, Vol. 28, Issue 1, pp. 1-46.

[49] J. Pereira (2011). Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls. *Current Oncology,* 18(2); Mary Shariff (2012), Assisted death and the slippery slope—finding clarity amid advocacy, convergence and complexity. *Current Oncology*, 19(3).

[50] Mary Shariff (2012), Assisted death and the slippery slope—finding clarity amid advocacy, convergence and complexity. *Current Oncology*, 19:3.

[51] The Honourable Sharon Carstairs (2010). *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*. Ottawa: Senate of Canada, at p. 24.

[52] Quality End-of-Life Care Coalition of Canada (2010). *Blueprint for Action: 2010 to 2020*. Ottawa: Author, at p. 1.

[53] Quality End-of-Life Care Coalition of Canada (2010). *Blueprint for Action: 2010 to 2020*. Ottawa: Author, at p. 1.

[54] Rubab Arim (2015). *A profile of persons with disabilities among Canadians aged 15 years or older, 2012*. Ottawa: Statistics Canada.

[55] David Baker and Gilbert Sharpe (2015), Draft Federal Legislation to Amend the Criminal Code to be Consistent with Carter v. Canada (Attorney General) 2015 SCC 5. Toronto: *bakerlaw*.

[56] The Royal Society of Canada Expert Panel (November 2011). *End-of-Life Decision Making*. Ottawa: Royal Society of Canada, p. 97.

TAB 3

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Court File No. 35591

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION AND GLORIA TAYLOR

APPELLANTS
(Respondents/Cross-Appellants)

- and -

ATTORNEY GENERAL OF CANADA

RESPONDENT
(Appellant)

- and–

ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENT
(Appellant)

AFFIDAVIT OF DAVID BAKER

I, David Baker, Barrister and Solicitor at bakerlaw, and counsel for the interveners, CCD and CACL, in the City of Toronto, in the Province of Ontario, AFFRIM AND SAY AS FOLLOWS:

1. Michael Bach, Executive Vice-President of the Canadian Association for Community Living was out-of-town in Sofia, Bulgaria, on a trip scheduled prior to the Federal Government's filing of the motion to extend the suspension in this case.

2. Mr. Bach confirmed that he had, when swearing the affidavit hereby sworn, before him a copy of precisely the affidavit to which, at his direction his electronic signature was affixed, and that he has seen and approved each exhibit attached to his affidavit.

3. He directed that his electronic signature was to be affixed following verbally swearing to the affidavit's contents via telephone on December 9, 2015.

4. I verily believe that Mr. Bach was fully aware in swearing to the precise substance of the affidavit, the truth of which he was swearing to, and the exhibits.

AFFIRMED BEFORE ME at the City of Toronto,

On December 9, 2015

Commissioner for Taking Affidavits	David Baker