



LIVING WITH DIGNITY

Bill C-7

**An Act to amend the Criminal Code
(medical assistance in dying)**

**Submission to the
House of Commons Standing Committee
on Justice and Human Rights**

November 10, 2020

Introduction

We would like to thank the Standing Committee on Justice and Human Rights for the opportunity to share a few comments on the content of Bill C-7, which was tabled in the House of Commons on October 5.

Since 2010, our citizen network has been closely following the evolution of end-of-life care in Quebec and Canada. We were founded in the wake of the publication of a document by the Collège des médecins du Québec in 2009 advocating "that in certain circumstances and at the end of life, or in the case of prolonged debilitating illnesses, euthanasia decided collegially with the patient or his or her family could be an appropriate way of providing relief and could be considered appropriate care. Since the Quebec National Assembly's Select Committee on the Right to Die with Dignity and the Quebec's *Act respecting end-of-life care* (also known as Bill 52 from its bill number), which came into force on December 10, 2015, and the federal law amending the *Criminal Code* (also known as Bill C-14 for the same reasons), which came into force on June 17, 2016, this gesture is now commonly referred to as "medical aid in dying" in Bill 52 and "medical assistance in dying" (MAiD) in C-14. Since that time, access to MAiD has been expanding year after year, either through a relaxation of the interpretation of the safeguards or through court decisions such as the one handed down by the Quebec Superior Court on September 11, 2019, commonly known as the Gladu-Truchon decision.

Since our mission is to "promote the protection of life, the inherent dignity and the accompaniment of persons made vulnerable by illness, old age or disability, in all circumstances and at all stages of their lives", we have spoken out at every pivotal moment of its expansion.

We are particularly concerned about the next step that Canadian parliamentarians are about to take with Bill C-7. In refusing to appeal the Gladu-Truchon decision, we understand that the federal government must now remove the "reasonably foreseeable death" criteria from C-14 which limited access to MAiD to only those at the end of life.

In light of this new expansion on the horizon, we feel it is essential to once again speak out on behalf of our more than 5,000 allies who have signed our manifesto (<https://vivredignite.org/en/about-us/declaration>) over the years.

Caring for the Vulnerable

Over the past few months, we have acted collectively with great prudence to protect the most vulnerable people during this time of pandemic. Faced with the distress of people at the end of their lives, people who are ill or living with a severe and incurable disability, we should invoke this same principle of prudence before further facilitating access to medical assistance in dying as proposed in Bill C-7.

We are challenged by the strong reaction of advocacy groups for people living with disabilities who vigorously denounce the current version of Bill C-7, which opens up access to assisted dying to people who are not at the end of life. Like them, we see that C-7 goes much further than what is necessary to give effect to the Gladu-Truchon decision.

While many of the witnesses invited by the Standing Committee on Justice and Human Rights call for the removal of more safeguards, we share the views of those who question the merits of amending or removing the safeguards already present in C-14.

In this brief, we will explore the importance of these safeguards for people at the end of life and for those who are not.

Safeguards for Persons at End of Life

Let us begin by examining the safeguards proposed to be abolished or modified for persons who are at the end of life or, as stated in C-14 and C-7, those whose "natural death is reasonably foreseeable".

The modification or abolition of these measures for persons who are at the end of life is an initiative of the federal government that, let us remember, is not necessary to comply with the Gladu-Truchon decision.

And it seems to us dangerous and hasty to do so at this time without a broader debate taking place as part of the review of the provisions of the current legislation that is to take place in early 2021 as mandated by section 10 of C-14. There is no urgency to do so without a thorough review of the effect of the current provisions on our society since 2016.

Currently, the written request for medical assistance in dying must be signed by the person requesting it before two independent witnesses. This was deemed necessary to avoid undue pressure on the person. We regret that C-7 now requires only one witness, which leaves room for all sorts of more or less subtle pressures from health care staff or even the patient's family.

The current federal law requires a 10-day delay between the request for medical assistance in dying and the accomplishment of this act; a very short delay but deemed necessary to allow the patient a period of reflection before this irreversible act. But, under the current law, even this short period of time can still be shortened if the physician or nurse determines that the person's death or loss of capacity to consent is imminent.

C-7 proposes that this 10-day cooling-off period be eliminated so that medical assistance in dying could be sought and obtained on the same day. We understand from your Parliamentary Committee's discussions that there is some disagreement on this, but it is clear that this possibility remains with the current wording of C-7.

The issue of ultimate consent is also very important to us. The *Criminal Code* requires that, immediately before providing medical assistance in dying, the patient must be given the opportunity to withdraw his or her request and providers must make sure that he or she gives express consent to receive medical assistance in dying. This requires that the person be of full capacity and conscious.

On the basis that some people are currently unable to receive medical assistance in dying because they have lost the capacity to consent at the time of the physician's action, C-7 now proposes to allow this requirement to be waived. The assisted dying procedure would nevertheless be carried out if, before the person loses capacity to consent, the person had entered into an arrangement in writing agreement with the physician or nurse authorizing the administration of a substance causing death on a specified date, had been informed of the risk of loss of capacity to consent before that date, and had consented, in the event of loss of capacity, to receive medical assistance in dying on or even before the specified date.

This relaxation is highly dangerous.

Of course, if, at the time of the injection, the person expresses his or her refusal or resistance to medical assistance in dying by words, sounds or gestures, it cannot be administered.

But C-7 goes even further. It even states that "involuntary words, sounds or gestures in response to contact "do not constitute a manifestation of refusal or resistance".

In practice, as the two doctors who perform the most medical assistance in dying in Quebec openly admitted at a public meeting called by Health Minister Danielle McCann in Montreal, which we attended on January 27, 2020, this does not pose a problem in practice, since if the patient is agitated, he or she is given a sedative and, once he or she ceases to be agitated, the lethal injections are given.

C-7 even provides that if a person, whether at the end of life or not, has lost the capacity to consent to receive medical assistance in dying after self-administering the substance provided by the physician or nurse to cause his or her own death, but his or her death has not occurred, then the physician or nurse may still administer the medical assistance in dying to that person if he or she had previously entered into an arrangement in writing to that effect. In other words, the doctor or nurse is allowed to "finish the job" in the case of a failed suicide.

These are all modifications or deletions of the safeguards already present in C-14 for people at the end of life that the federal Parliament had deemed essential less than five years ago to prevent abuse and these modifications or deletions are not necessary to give effect to the Gladu-Truchon decision.

Medical assistance in dying for people who are not at the end of life

The most important measure in this bill remains the introduction by C-7 of medical assistance in dying for those who are not at the end of life.

These may be people who are ill, those living with one or more disabilities or those who have a medical condition, for example, as a result of a car or work accident or even a suicide attempt. Of course, their medical situation must be grievous, irremediable and characterized by an advanced and irreversible decline in capability and this condition must cause them enduring, intolerable physical or psychological suffering that is intolerable to them and that cannot be relieved

under conditions that they consider acceptable. But these people are not at the end of their lives.

C-7 provides safeguards to prevent abuse. The person must meet all the criteria. The request must have been submitted after the person was informed that he or she has a grievous and irremediable medical condition. It seems to be overlooked, however, that the person receiving this kind of news is in shock and that it is difficult for that person to give a free and enlightened consent to receive MAiD.

They must have been informed that they can withdraw their request at any time.

The fact that the person meets all of the criteria must have been confirmed by two independent doctors, one of whom must be an expert in the condition that causes the person's suffering.

It must have been ensured that the person has been informed of the means **available** to relieve the person's suffering. And it must also have been ensured that the physician or nurse who will perform MAiD have discussed with the person the **reasonable and available** means to relieve the person's suffering and that they agree with that the person has given serious consideration to those means.

These promised "additional safeguards" for people whose end of life is not imminent seem very weak to us. While in the Netherlands a physician must confirm that there are no other potential means to relieve suffering before euthanizing a patient, Bill C-7 only specifies that the physician or nurse practitioner who will practice MAiD must "ensure that the person has been informed of the means available to relieve his or her suffering, including, where appropriate, counselling services, mental health support services, disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care" and that he and the other health professional agree with the person that "that the person has given serious consideration to those means". There is no obligation on the patient to try other options; in fact, there is no obligation to even make these means accessible. This diminished safeguard puts many vulnerable people at risk, particularly those with disabilities, as the care and support measures for them are so deficient. The call of these individuals and of all

groups defending them was ignored in C-14, in the Gladu-Truchon decision, and C-7 shows an even greater misunderstanding of their situation.

C-7 also proposes a period of at least 90 days between the first assessment and the day on which medical assistance in dying is provided. But again, as in the case of a person at the end of life, this period may also be shortened if the loss of capacity to consent is imminent.

Think, of course, of people who are newly diagnosed with Parkinson's, think of people who are newly disabled as a result of an accident. 90 days is not enough time for them to adjust to their new condition, these are all vulnerable people that C-7 puts at risk. It is well known that it takes years for the suicide rate of people who suddenly find themselves in this situation to drop to the level of the general population. Do we really believe that three months is enough time to go through such difficult emotional upheaval?

Conclusion and Recommendations

Other witnesses have pointed this out before us, but we believe it is pertinent to recall the words of the UN Special Rapporteur on the rights of persons with disabilities. In her End of Mission Statement of April 12, 2019, she noted that our federal government was "still lags behind in the implementation of its obligations under the *Convention on the Rights of Persons with Disabilities*". And, in her final report released after the Gladu-Truchon decision, she raised the fact that the judgment "might put additional pressure on persons with disabilities who are in a vulnerable situation due to insufficient community support."

She even added: "As many persons with disabilities said during the visit, they are being offered the 'choice' between a nursing home and medical assistance in dying."

In this context, it seems to us essential to act with much more wisdom and prudence with regard to the safeguards surrounding medical assistance in dying in the context of the Gladu-Truchon decision.

Indeed, we find it difficult to understand how the federal Parliament could both adopt the proposed measures which would make Canada the most permissible country in the world concerning MAiD while at the same time representing in the Preamble to C-7, as was done in the Preamble to C-14, that "Parliament affirms the inherent and equal value of every person's life", that " it recognizes ... the important public health issue of suicide", and so on.

Limiting access to MAiD to persons who are not at the end of life

The 90-day waiting period does not seem to us to be sufficient to prevent vulnerable people from choosing death within these limited timeframes, particularly in the case of a sudden incurable illness or disability, for example as a result of an accident. We fear that many of the people who will opt for medical assistance in dying will do so because of our inability to adequately accompany them in their distress. For a longer period of time, the patient should be informed of the care that could be offered to relieve his or her suffering. Obviously, this care should be made truly accessible.

The door that we are about to open will affect a significant portion of the population, including all those with chronic diseases (lungs, heart, kidneys, diabetes, neurological conditions, osteoarthritis). To treat them effectively and with dignity, significant resources should be mobilized long before thinking of offering them an induced death.

While we are pleased that mental illness alone would not be a sufficient criterion for accessing medical assistance in dying, we know that many people suffer from both physical and psychological disorders. In these cases, which are more frequent than one might imagine, it will be very difficult to discern whether the suffering invoked affects the body more than the mind. We believe that the bill should be more cautious about opening the door to people suffering from mental illness to ensure that this condition is never their reason for opting for medical assistance in dying.

There is no obligation for the government to change the safeguards for people who are at the end of life.

With respect to the part of Bill C-7 that addresses the issue of medical assistance in dying for people who are at the end of life, our recommendation is simple: do not change the minimum safeguards already in place.

By removing the 10-day period for medical assistance in dying and the final consent prior the lethal injection, we are about to make a serious mistake. Knowing that, according to various official reports, the current safeguards are not always complied with (yet with no disciplinary measures against offending physicians), these withdrawals seem to us to be very imprudent.

We understand the reasons given for respecting the autonomy of individuals, but this lethal gesture has no return. Many events, whether therapeutic, relational or other, can occur during this short period. Regardless of the number of patients who may change their mind within 10 days or at the time of final consent, we must preserve this possibility for them and their loved ones.

Finally, in light of certain court decisions that have undermined the conscientious objection of health care personnel, it would be advisable that the current provisions of subsection 241.2 (9) of C-14 be strengthened to clearly state that

nothing in this Act can compel an individual to refer a person seeking medical assistance in dying to a colleague willing to carry it out.

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There are times in our lives when we may be extremely vulnerable. It changes the way we view our present and our future. We need to propose concrete solutions to help restore meaning to life for those who have lost it, often temporarily. Let us remember that restrictions in the quality of our physical capacities do not necessarily imply or equate to a lessening of our total, personal, inner and relational quality of life.

This legislative project, like those that paved the way for euthanasia in this country, gives the false impression that a person's dignity is essentially dependent on his or her autonomy. By administering medical assistance in dying to the person who requests it, one would supposedly respect his or her dignity (a dignity, however, that is inherent in every person, irrespective of their degree of autonomy). In such a discourse, it is implied that in order to die with dignity one must necessarily die earlier, from a death that is administered, chosen and above all anticipated. What a sad state of affairs.

The obligation to respond to the Gladu-Truchon decision by December 18 should not prevent our federal elected officials from significantly amending Bill C-7, for the benefit of the most vulnerable, but also for our collective good, and from postponing to the time of review of the law all aspects that are not necessary to follow up on this decision.



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