From: Barbara Brzezicki
Sent: February-01-16 7:45 PM
To: Physician-Assisted Dying Committee Comité Aide médicale à mourir
Subject: Parliament’s Special Joint Committee on Physician-Assisted Dying

Dear Special Joint Committee on Physician-Assisted Dying,

- Canadians deserve a fair and compassionate federal legislative framework. I urge you to consider the following as the Parliamentary Committee drafts recommendations for new legislation

- “Considerations for best practices and protocols for physician assisted dying should include...”

- “The following recommendations should be considered when drafting laws surrounding physician assisted dying...”

Eligibility

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1. “Grievous” is defined as a very severe or serious illness, disease or disability; a list of approved qualifying conditions must not be compiled.

In its decision in Carter v. Canada, the Supreme Court decriminalized physician assisted dying for competent adult patients who have a “grievous and irremediable” medical condition that is intolerable to them. Because “grievous” is a judicial term and not a medical one, many stakeholders have asked for Parliament to clarify how the word should be interpreted in a healthcare context.

DWDC believes that a list of approved qualifying conditions would unfairly impede access for some patients who are experiencing grievous and irremediable suffering. Thus, eligibility should not be limited to a list of approved conditions and should instead be open to patients with a “very severe or serious illness.”

2. Advance requests for assisted death are valid when made by a patient who, at the time of the request, was competent and had a diagnosis for a condition that was or could become grievous and irremediable.

This is a critical issue. Parliament must act to ensure that patients whose requests for PAD have been approved — but who then become incapacitated as the result of a stroke or a coma, for example — are still allowed to have their wishes carried out.

Furthermore, denying Canadians the option of requesting PAD in advance could lead some patients (for example, those with an early dementia diagnosis) to seek aid in dying too early, or worse: to end their lives on their own while they still have the ability to do so.

Advance requests for assisted death should be valid when made by a patient who, at the time of the request, was competent and had a diagnosis for a condition that was or could become grievous and irremediable, including dementia.

Provisions to Protect Patients

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DWDC recommends that two physicians assess a patient and verify that the requesting patient has made a free and informed decision. Outside consultations are unnecessary unless the patient's competency is in question.

3. Two physicians must verify free and informed consent.

4. Every case is reviewed after the patient has died. Aggregate data is compiled and made available to the public.

To ensure adequate tracking, each case of PAD must be recorded for research and statistical purposes.

Provisions to Ensure Reasonable Access

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5. Other licensed healthcare practitioners may also provide assisted dying to ensure access, especially in remote regions.

Other healthcare practitioners, such as nurses and physicians' assistants, must be granted permission to participate in assisted dying under the supervision and guidance of a doctor. In many remote communities, there is a severe shortage of physicians. For that reason, other registered healthcare professionals should be allowed to assist in the provision of PAD. This measure would help ensure that eligible patients are not abandoned or denied their constitutional right to a peaceful death.

6. Doctors have the right of conscientious objection but must provide information and effective referrals (or transfers of care) to an institution, independent agency or other provider.

DWDC strongly believes in choice, both for the patient and the physician. While physicians may refuse to provide PAD for reasons of conscience, they must not abandon patients. Physicians who oppose assisted dying must be required to refer patients who request it to another doctor or a third-party referral agency. Sick and dying patients should not be responsible for finding an alternate doctor on their own.

7. Publicly funded healthcare institutions, including hospitals, hospices and long-term care facilities, are required to provide physician-assisted dying on their premises.

All publicly funded healthcare institutions must allow PAD on their premises. If no doctors on staff are willing to provide, an external doctor must be permitted into the hospital to provide the service. This policy is especially relevant for small communities where healthcare options may be limited. For example, some communities may only have Catholic-affiliated hospitals or hospices nearby. If those institutions refuse to provide PAD on their premises, then access to PAD will be heavily restricted in the communities they serve.

Even in larger centres, a patient may be rushed to an emergency department at a Catholic hospital. Moving the patient to a non-denominational institution would cause unnecessary stress and may not be possible depending on the patient's condition.

Thanking the Joint Committee for its consideration.

Sincerely,

Barb Brzezicki