CSPCP SCMSP
Canadian Society of Palliative Care Physicians
Société canadienne des médecins de soins palliatifs

Submission to the Standing Committee on Justice and Human Rights on Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)

October 30, 2020

This document was created in an effort to best reflect our membership. Recommendations may be different from the personal opinions of individual Society members.

Background

The Canadian Society of Palliative Care Physicians (CSPCP) acknowledges the Minister of Justice's reintroduction of Bill C-7 An Act to amend the Criminal Code (medical assistance in dying) (1). We are concerned that the proposed changes to the current Medical Assistance in Dying (MAiD) legislation in response to the Quebec Superior Court's Decision in *Truchon and Gladu* may negatively impact optimal patient care and exacerbate the existing challenges of ensuring equitable access to and provision of palliative care to patients and their families. As the national specialty society of palliative care physicians, the CSPCP is dedicated to seeing that all Canadians have access to high quality palliative care.

Our concerns with the proposed legislative changes for MAiD are outlined below with our recommendations to ensure that the necessary safeguards are in place to minimize harm to vulnerable Canadians and to highlight the importance of palliative care. Many of these recommendations are consistent with the CSPCP's original submission to the External Panel on Options for a Legislative Response to *Carter V. Canada* (2), which remain applicable to the current context.

CSPCP Recommendations:

1. Recommendation to prevent premature death

Removal of the reasonably foreseeable natural death (RFND) criterion risks prematurely ending the lives of those with disabilities or chronic diseases, who may not be dying and are lacking the support or appropriate care needed to reduce suffering and improve quality of life in order for them to focus on living. It may also entrench stereotypes and exacerbate stigma for Canadians with disabilities who already face inequity around access to care, and sends a message that disability-related suffering justifies the termination of a person's life (3).

Time is often necessary to ensure careful assessment of an illness, proper diagnosis, impeccable symptom management, and appropriate monitoring of treatment interventions that can provide benefit to a person facing a new illness or situation. When a new and often complex reality is being faced, an individual may normally experience an existential crisis and question the meaning and value of their life. With time and support, a person can come to a new sense of normal and find meaning in their circumstance. This may take many months or even years for some people. Unfortunately, access to specialist care, which is often needed for complex situations, can take many months to obtain. Any professional assessing a patient's request for MAiD must have access to appropriate consultative support for that patient according to their need. This may include palliative care, psychiatry, chronic pain specialists, gerontologists, physiatry, spiritual care, and services to support people dealing with mental health issues, substance use disorders, disabilities, as well as physical and social isolation. This would ensure all reasonable treatment options have been provided to manage physical, psychological, social, spiritual, and emotional suffering. Simply having information about the available treatment options is not enough; people need the lived experience of care to make an informed decision. Under the proposed two-track system for those without a RFND, a 90-day assessment period may not provide sufficient time for a person to receive appropriate palliative care or other supports needed to reduce suffering and live with dignity. Instead, they may feel that premature death via MAiD is the only option. This may also lead to people "requesting MAiD" to jump the queue to access these needed services.

2. Recommendation for minimum safeguards to reduce risk of coercion for vulnerable persons

The Supreme Court ruling in *Carter v. Canada* stated that a carefully designed system of safeguards would be needed to minimize harm to vulnerable persons. The C-14 legislation (4) subsequently puts in place certain safeguards for persons with a RFND. Bill C-7 now problematically proposes to remove some of these safeguards, including the requirement for two independent witnesses and a 10-day reflection period.

These safeguards serve as a way to ensure people, particularly those who are vulnerable, have additional protection from the risk of coercion and to reduce the risk of wrongful death. We recommend these original safeguards be maintained. Without a reflection period for people with RFND, the result may be the unintentional expediting of the process of MAiD without allowing a person the time to change their mind. Moreover, intolerable suffering from a "grievous and irremediable medical condition" can often be contextual and subject to the perspectives, experiences, and limitations of the involved clinicians. Having witnesses who are not part of the healthcare team is essential to reduce risk of coercion.

3. Recommendation to maintain requirement for capacity to consent at the time of provision of MAiD

A person should be able to change their decision up until the time of the procedure. The proposed changes in Bill C-7, however, remove that opportunity from a person who loses capacity after previous consent. Furthermore, the determination of whether or not a person does wish to withdraw their request after losing capacity to consent by way of words, sounds or gestures, is problematic in its potential subjectivity and may put clinicians in a precarious situation by having to interpret these responses. MAiD may be requested simply because the level of care required by the patient who has lost capacity exceeds what is currently being provided.

4. Recommendation on bringing up MAiD

To safeguard against any possibility of subtle or overt pressure on patients, health care professionals should not initiate a discussion about MAiD or suggest the option of MAiD unless brought up by a patient. If a patient raises questions or requests MAiD, health professionals should have the ability to explore these issues, including their underlying suffering, and provide information or direct them to someone who can provide information (5). In other jurisdictions where assisted dying is legalized, such as in the recent legislation in Victoria, Australia, this risk of coercion due to the hierarchy and differential of expertise present in the physician-patient relationship is addressed directly in the law. Victorian Legislation states that a healthcare practitioner must not initiate a discussion or suggest Voluntary Assisted Dying (VAD) to a patient (6). We urge the Federal government to reduce harm of coercion to vulnerable patients by including this in the current revisions to the Canadian MAiD legislation.

5. Recommendation to provide meaningful conscience protection for healthcare professionals with respect to MAiD

Physicians who do not wish to participate directly or indirectly in MAiD should have their integrity and fundamental freedoms, including freedom of conscience, protected (5). Although conscience is often simply portrayed as "for" or "against" MAiD, in practice it is much more nuanced. Each individual may have inherent values and moral beliefs that determine their level of participation or non-participation which must be respected. Expected physician participation in MAiD in Canada far exceeds that of other permissive jurisdictions in the world. Federal legislation is needed to provide meaningful protection for healthcare professionals from being compelled or required to participate in MAiD, such as is provided in the Victorian Legislation in Australia (6).

6. Recommendation to prioritize palliative care as a distinct service from MAiD

CSPCP strongly advocates for the prioritization of, adequate investment in, and enhancement of palliative care services as outlined in #7 below. Without access to high quality palliative care, some patients who are suffering may feel that MAiD is their only option because their suffering has been inadequately addressed or they perceive that their families or social supports must carry an excessive burden (2). Although one recent study indicated 82.1% of individuals receiving MAiD reportedly received palliative care services, the adequacy of the services offered was not determined nor was it articulated how palliative care services were defined, what criteria were used to determine the involvement of palliative care, and if these involvements were adequate (7). Data regarding availability, access, quality and types of palliative care (e.g. specialist palliative care, primary palliative care or palliative approach) are essential, not only for those requesting or receiving MAiD, but in general, in order to better inform areas for improvement.

Palliative care should remain distinct from MAiD to ensure clarity and to avoid the risk of confusion and the potential for people to refuse palliative care services (5, 8). This does not, however, preclude people who contemplate, request, or opt for MAiD from receiving palliative care. This is particularly vital for people in communities that have an underlying distrust of the healthcare system who decline palliative care because they may confuse it with MAiD.

7. Recommendation for funding to make comprehensive palliative care a reality in Canada

The CSPCP strongly advocates for universal access to high quality, comprehensive palliative care to address the suffering experienced by patients with life-threatening illness and their families. In order to achieve this, we need to:

- Increase funding to support the implementation of the Action Plan for Palliative Care (9) set out in Health Canada's Framework for Palliative Care in Canada (10)
- Improve access to Specialist Palliative Care physicians with appropriate training and certification in palliative care as outlined the CSPCP Delivery of Palliative care by Physicians in Canada: A Definitions Document (11). Specialist palliative care is required for complex palliative care issues in partnership with primary palliative care supports
- Set clear national standards and accountabilities for palliative care programs including accreditation standards
- Gather consistent and ongoing data regarding access and quality indicators for palliative care
- Set and monitor standards for the education of all health care providers in appropriate skills in advance care planning and in a palliative approach to care
- Create supports for patient and family caregivers including quality information about palliative care services, advance care planning tools, income support and job security
- Develop a national funding plan to transition an integrated palliative care approach to care from acute care hospitals to more community-based locations
- Advise on a national public education campaign around advanced care planning, palliative care and demystifying death and dying

CSPCP's vision is for all Canadians have access to high quality palliative care.

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About the Canadian Society of Palliative Care Physicians

The Vision of the Canadian Society of Palliative Care Physicians is to promote access to palliative care for all Canadians, through advocacy, partnerships, research, and physician education. Our membership consists of approximately 600 palliative care physicians, including regional and local program leaders, educators, residency directors, clinicians, and palliative care residents.

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