

BRITISH COLUMBIA HUMANIST ASSOCIATION

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Dear External Panel on Options for a Legislative Response to Carter v. Canada,

The British Columbia Humanist Association supports the right of an individual who has made a clear decision, free from coercion, to choose a physician-assisted death. We urge the next Parliament to work together with the provinces to create a legal and regulatory framework that grants the right to a physician-assisted death to all Canadians who freely choose it.

Since 1984, the British Columbia Humanist Association has campaigned for progressive and secular values. Humanism is a worldview that promotes human dignity without belief in a higher power. We believe that the promotion of human dignity requires allowing an individual to choose both how to live and how to end their life. People who have made the decision to end their life should have access to the means and assistance to do so with dignity.

Minimal eligibility criteria

We support legislation to give all Canadians the right to freely choose a physician-assisted death. We do not believe there is a strong moral case to limit access just to those who have “a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition,” as in the Supreme Court of Canada’s decision in Carter v. Canada 2015.

Anyone mature enough to give an informed and voluntary consent should be free to choose a physician-assisted death. It is the right of a competent individual to determine whether they are ready to end their life.

Reasonable safeguards

Safeguards to ensure that decisions are free, voluntary, and informed will be essential to any regulatory regime but they must not make access unjustly difficult. Claims that legalizing physician-assisted dying will lead to a “slippery slope” where vulnerable people will be taken advantage of are refuted by the best available evidence. A thorough review of evidence from Oregon and The Netherlands concludes: “There is no current evidence for the claim that legalised [physician-assisted dying] or euthanasia will have disproportionate impact on patients in vulnerable groups.”¹

¹ Battin MP, van der Heide A, Ganzini L, van der Wal G. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups. *Journal of Medical Ethics*. 2007;33(10):591-597. doi:10.1136/jme.2007.022335.

In order to receive an assisted death, an individual must be competent and make a free, voluntary, and informed decision. Physicians regularly assess patients' competence to make life and death decisions. We rely on their expertise in assessing competence and determining when they need additional information to do so.

We support the "Supports and Procedures" set out in *A Proposed Framework for Physician-Assisted Dying* by Dying With Dignity Canada². A second, independent physician should be required to provide written confirmation that the patient has made a free, voluntary, and informed decision and meets the criteria for access to physician-assisted dying. This will ensure that the patient is competent and is not being coerced into a decision that they would not otherwise make. A specialized capacity assessment may be sought by either physician if they have any uncertainty about the patient's capacity to provide informed consent. An individual whose request for a physician-assisted death is declined would have the right of timely appeal.

Physicians, who regularly judge a patient's competency, are sufficiently qualified to attest to whether a patient is making a free, voluntary, and informed decision. Additional psychological tests only serve to create further barriers to access and needlessly restrict patients' rights.

We also expect physicians to honour a patient's request for a physician-assisted death when that request is made freely and explicitly in advance, for example through an advance care directive (or similar living will).

We do not support mandatory waiting periods because they are necessarily arbitrary and do not reflect individual circumstances. The determination of whether the request for assistance is enduring should be part of the physician's assessment process. We believe physicians are best positioned to assess the need for waiting periods and should do so on a case-by-case basis.

We are strongly opposed to any requirement that a patient would have to consult with anyone besides their physician, particularly a pastor or religious leader. Choosing to end a life is a personal choice between a patient and her or his physician.

We do not support establishing independent panels to determine the legitimacy of an individual's request to have a physician-assisted death. Such requests should remain between a patient and her or his physician. Therapeutic Abortion Committees in the 1970s and 80s showed that such panels severely restrict access and create large discrepancies in availability between jurisdictions across Canada. We have no reason to believe that physician-assisted dying committees would result in a more just provision of services.

Guaranteed access

The Supreme Court's decision is clear: Eligible Canadians have the right to a physician-assisted death. This right should be enshrined in the publicly-funded Canadian healthcare system to guarantee access.

² Dying With Dignity Canada 2015 Draft Policy Framework.
http://www.dyingwithdignity.ca/principles_for_legislation Accessed: Sep 9, 2015

Guarantees must also be provided to ensure access for people who cannot speak or write. Patients should be able to present their request for a physician assisted death in writing or orally.

Health care institutions (including but not limited to hospitals, hospices, residential or long-term care facilities) that receive public funds should be required to allow physician assisted death within the institution. Institutions that refuse should see their funding withdrawn.

Provide options for physician-assisted deaths

We believe that all reasonable options for physician-assisted deaths (injection or oral by physician or oral by prescription) should be available to Canadians. There is no moral difference between a physician prescribing a pill for a patient to end her or his own life and the physician administering a life-ending treatment. There is a difference for some, however, in the ability to self-administer medications, so restricting physician-assisted dying to prescriptions discriminates against some patients.

Wherever feasible, individuals should be able to choose the location to end their life, for example, in the home, a hospital, or hospice.

No conscientious objections

We do not support so-called “conscientious objection” clauses that permit physicians and pharmacists to opt-out of doing their jobs because of their personal beliefs. Medical professionals have a responsibility to respect their patients’ autonomy and their dignity. Therefore the right of an individual to receive a physician-assisted death outweighs any personal, ethical, or religious objections of a medical professional.

If allowances for conscientious objections are permitted, such allowances must be rare, unrelated to belief in a deity (or deities) or other supernatural entities, and applied in a manner that places first priority on the patient’s wishes. Objections should not interfere with or obstruct a patient’s right to a physician-assisted death. Physicians and pharmacists should be required to provide information about physician-assisted dying according to the established norms of informed consent law. Physicians who are not prepared to provide physician-assisted death and pharmacists who are not prepared to fill prescriptions for life-ending medication should be required to provide effective and timely referral. Patients in remote areas should be guaranteed equal access as those in major cities and should not be required to travel to obtain a physician-assisted death.

Collecting statistics

Data on requests for physician-assisted deaths and subsequent outcomes should be collected. Such data will be vital to ensure we know if access is equitable and to highlight other issues as they arise. Summary results from these data should be publicly released and data (stripped of personally identifiable information) should be available to independent researchers.

Concerns over the panel’s impartiality

Finally, we are concerned that of the three members on the panel two were witnesses who testified against physician assisted dying for the Government in *Carter v. Canada*. The online “Issue Book” released by the panel is particularly problematic as it chooses to rehash debunked arguments, fails to

present the robust evidence from jurisdictions where physician-assisted dying has been legalized, and attempts to sow fear about supposed “risks from physician-assisted dying”.

We are encouraged by the leadership shown by the Ontario Government’s concurrent consultation on physician-assisted dying and the new law to allow physician-assisted dying in Quebec later this year, which followed widespread consultation. We hope the panel will consider the results of both of those consultations.

Conclusion

It is time for Canada to take a leadership role on the right to die with dignity. Parliament should make it the right of every individual to freely choose to end their life and to have access to the means to do so. The risks of future legislation and regulations are that access is limited, that the rights of individuals will be infringed, and, most critically, that individuals will continue to suffer needlessly.

We thank the members of the panel for their time and efforts in considering this important issue. We look forward to the outcome of your consultations.

Sincerely

Ian Bushfield
Executive Director
BC Humanist Association