## C-14 First Reading offers no substantive control, amendments suggested

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This submission attempts to demonstrate that C-14, First Reading, offers no substantive control on access to "medical assistance in dying." Complaints that C-14 is too restrictive are not credible.

This analysis is predicated on the fact that C-14, First Reading, states no specified limit on the number of doctors who can be successively approached with a request for "medical assistance in dying." There is no requirement that a doctor take into account the outcome of any previous request by a patient for "medical assistance in dying" including specifically whether such a prior request ended in a finding of ineligibility.

C-14 as currently written contains 9 eligibility subclauses specifying **16 concepts to be decided.** Two are objectively transparent, 10 are decided by the doctor, and 4 are decided by the patient. (This submission uses "doctor" to mean "doctor or nurse practitioner." ) The **16 decision points**, and who decides them, are:

Eligible for government health funding: objective, transparent

Age over 18: objective, transparent

Capable of decisions regarding health: judgment by doctor

A disease or disability is present: doctor

Serious: doctor

Incurable: doctor

Advanced state: doctor

Irreversible decline: doctor

Enduring: judgment by patient

Physical suffering: patient

Psychological suffering: patient

Acceptable means of relief: patient

Foreseeable death: doctor

Request truly voluntary: doctor

No external pressure: doctor

Informed consent: doctor

The 4 decision points which are determined by the patient's subjective world cannot by their nature act as safeguards.

Of the 10 decision points left to the doctor, two (**seriousness and advanced-ness**) are arguably "subjective" and left for the doctor to decide, but in any case not defined.

Two more (**incurability and irreversibility**) are characteristics of almost all the patients who will be eligible and in any case fall under the shadow of "irremediability" which is, as per *Carter*, at the discretion of the patient who may be spoken for by a representative.

Two more ( **actual presence of disease and foreseeability of death**) might be thought to be objectively transparent but, stated otherwise as diagnosis and prognosis, can be in reality fraught with error. The Act **prevents any legal consequences** in the case of a **wrongful death** under the Act caused by "reasonable but mistaken belief" about "any fact."

The final four concepts are **capability, voluntariness, freedom from external pressure, and therefore informed consent.** I am a practicing physician with 35 years of experience, including the preparation of approximately 100 formal medicolegal capability assessments. I can attest that for these final four criteria for eligibility, arriving at an informed opinion can be bewilderingly difficult. No guidance in this realm is offered by C-14, First Reading, except that 241.1(7) expects "reasonable knowledge, care and skill" while the doctor's "mistaken belief" about "any fact" is excused by 241(6). It is hard to imagine legal action against a doctor who undertakes this difficult exercise in subjective good faith. If *Carter* expected that there would be rigor in the process, it is not to be found here.

Although it might be assumed, nowhere is it specified that the doctors must actually examine the patient, to what extent they must do so, or *to what extent* the doctors must inquire into the internal and external factors creating vulnerability for the patient. It is hard to know what is going on at home.

This lack of requirement for the two doctors to deeply engage with the patient begins with the acceptance by the doctors of a written request which can be created before two witnesses by someone representing the patient who purports to understand the "nature of the request" . The doctors do not have to meet, or assess the motives of, the representative. The patient, representative and two witnesses must be physically together at some point in time but a doctor does not have to be present at that time. The two witnesses are not required to have any understanding of the situation other than that a request is being

signed and dated. The witnesses are not expected to have any knowledge of the patient's decision making capability or the representative's motives.

Because under the draft Act **any number of physicians** may be canvassed by anyone to find two who approve of death in any given patient's situation, the above **16-concept analysis** makes clear that, in the daily life of a Canadian hospital or nursing home or home care location, **any candidate** could invoke the general principles set out in *Carter* to access these practices. This opens the door to wrongful deaths, deaths to which patients could be steered, by their own hopelessness or the agendas of others, to throw away years of their lives.

That **any two physicians** could play the gatekeepers to this system is dangerous, unnecessary, and correctible by a straightforward amendment:

Immediately after 241.2(3)(g) place the following:

(h) obtain an order from a judge who is satisfied with the application of the criteria and safeguards of Section 241.2 to the unique situation of the person, with special attention to 241.2(1)(d);

The clause currently numbered 241.2(3)(h) states: " immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying."

This should be renumbered as 241.2(3)(i) and "immediately before" changed to "at the time of" to reduce the chance of abuse in the following situation: The draft Act provides for a lethal dose of medication to be transferred to another person, not the doctor, who wishes to assist with the provision of death. In real life there may be a delay of some time before that assistance is provided, and in order for that action to be supervised for voluntariness and consent at the actual time of death, the doctor would have to be present.

It is simply not acceptable to invite foreseeable wrongful deaths as the price of easy access to an assisted suicide and euthanasia system. These two amendments have the potential to reduce harm.

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