May 1, 2016

The Standing Committee on Justice and Human Rights
House of Commons
131 Queen Street, 6-07
Ottawa, ON, K1A 0A6

Dear Committee Members,

Thank you for the opportunity to provide comments on Bill C-14. Our comments are from the perspective of physicians who have been providing care to an inner city population including those who are food and housing insecure, new immigrants and victims of violence for many years. Our opinions are not representative of the institutions with which we are affiliated.

We believe that Bill C-14 in its current form, limiting eligibility for medical assistance in dying (MAID) to those who are competent adults at the time of the procedure / prescription and in an advanced state of irreversible decline in capability and whose natural deaths are reasonably foreseeable, represents the absolute minimum standard to protect vulnerable Canadians.

We would like to share 3 areas of concern in reviewing Bill C-14.

1. Logistic issues in clinical medicine:

1.1 Incompatibility between suicide prevention and the provision of MAID in clinical care

A. Suicidal ideation can be part of the symptomatology of mood disorders such as depression. Current best practice guidelines mandate physicians to place a patient with concrete plans for self harm, such as to overdose on medications, under Form 1 for mandatory psychiatric assessment. From our understanding, there has been no scientific evidence to validate or guide where the threshold between suicide prevention and MAID provision lies.

B. Adequate therapeutic response to antidepressants can take up to six weeks or more. A 15-day minimum waiting period is hardly sufficient for any meaningful therapeutic response.

1.2. Limitations of relying exclusively on physicians for assessment of voluntariness and valid consent

A. Quite a number of patients have expressed self harm thoughts in our practices over the years. While some of these thoughts are related to their mental illness, some are related to feelings that they have no one or nowhere else to turn for reasons ranging from being abused, having unmanaged pain, grief, financial duress and housing difficulties to concerns about being a burden to their loved ones. With these cases, a multidisciplinary team including clinicians, nurses, social workers and an income security expert would assess and help remedy the patient's situation using a multifaceted approach. The patients usually change their minds once their problem is relieved. It is virtually impossible for any individual physician to be able to identify and attend to the many external factors that may unduly influence patients to seek MAID. MAID should not be the cure for social ills and no one must feel an obligation to die.

B. Translators are not always readily available and it is not uncommon that patients receive procedures without understanding them. This is often only discovered when they discuss this with their language concordant provider at a later date.

C. Victims of abuse can take years to build trust with their providers before disclosing. While there are screening tools for abuse, they do not have 100% accuracy. It is not unforeseeable that a patient may seek MAID under the pressure of their abuser without this being detected by a provider.

With these logistic issues in mind, we request that the Committee consider an amendment to require a priori culturally sensitive multidisciplinary vulnerability assessment to adequately investigate and address any external factors leading the patients to seek death. This is a critical safeguard to ensure that suffering from physical, spiritual and psychosocial sources will be recognized and that patients will be supported to consider options that might relieve their suffering without having to resort to MAID.

In addition, given the challenges in drawing a clear line between suicide prevention and the provision of MAID, an a priori judicial review for exemption to the existing criminal code should be required for any MAID request.

2. Monitoring and Accountability issues:

A three-year Review of Federal Inmates Suicides (2011-2014) as well as the Coroner's inquest concerning Ashley Smith have demonstrated that Canada's correctional system is ill equipped to appropriately deal with mental health issues. "Cries for help" have been misinterpreted, leading to the preventable death of inmates. Without a reform in prison mental health care, Bill C-14's proposal to waive the necessity to investigate inmate deaths according to the Corrections and Conditional Release Act may have the unintentional effect of MAID being used in an inappropriate, unmonitored and

unreported fashion. We would urge you to leave Section 19 of the Corrections and Conditional Release Act intact.

3. Equity and Charter Rights to Liberty and Security:

For any law to be just, it cannot further the marginalization of particular groups of its citizens. There are groups of vulnerable patients who have trouble trusting institutions and seeking care. These very patients may be fearful of seeking medical help should MAID be mandated in every institution and by every provider. It is critical for the Committee to create safe spaces for these patients by providing exemptions to objecting institutions and providers.

Similarly, legislation should prevent systematic discrimination of an entire group of clinicians who espouse the established purpose of medicine: to heal and to avoid inflicting the ultimate negative outcome - death.

Finally, robust monitoring and research should ascertain that the legalization of MAID is not going to exacerbate or mask existing suicide crises in certain communities, such as our First Nations Communities.

In this context, the necessity for monitoring must not be left entirely to discretionary regulations, but must be recognized in the legislation as an essential protection of the Charter rights of vulnerable persons.

We are thankful to the Committee for considering our comments.

Sincerely yours,

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