Vulnerable Persons Standard | Norme sur la protection des personnes vulnérables

# Frequently asked questions about the Vulnerable Persons Standard

## 1. What is vulnerability and who is vulnerable?

To be vulnerable is to have diminished defences, making us more prone to harm. Many Canadians are fortunate to have defences that we can take for granted: food and secure shelter; adequate income, education and healthcare; family and friends; laws and policies that protect us and promote our interests. Regrettably, however, this is not the case for every Canadian.

Research demonstrates that these kinds of defences – often referred to as the social determinants of health – are highly significant in affecting our health and well-being. People with less access to these defences are more vulnerable to illness, to suffering, and to reduced life expectancy.

Psychosocial factors, including grief, loneliness, stigma and shame may also contribute to a person's vulnerability. A person may also be vulnerable to being induced or coerced to request an assisted death, which is why it is essential to address this risk with a Vulnerable Persons Standard.

Vulnerability can compromise autonomy in ways that are often difficult to detect. The Vulnerable Persons Standard provides a benchmark to evaluate the effectiveness of any safeguard system in preventing the potential harms created by permitting access to physician-assisted death.

## 2. Why is the Standard important?

The Vulnerable Persons Standard is rooted in the Supreme Court of Canada's conclusion that a "properly administered regulatory regime is capable of protecting the vulnerable from abuse and error."

People who request a physician-assisted death can be motivated by a range of factors unrelated to their medical

condition or prognosis. These factors make some people vulnerable to request an assisted death when what they want and deserve is better treatment – to have their needs for care, respect and palliative and other supports better met. The Supreme Court of Canada recognized this reality. While it found that the absolute ban on assisted suicide breached a suffering person's right to autonomy in some cases, it also found that an exception to the ban could make some people vulnerable to abuse and error. Therefore, access to physician-assisted death must be balanced by our moral and constitutional duties to protect vulnerable persons who have unmet needs.

**3. Is the standard only required for 'vulnerable groups', like people with disabilities?**

No. While some identified social groups, like people with disabilities, frail seniors and other marginalized communities are less well served by the social safety net and therefore more likely to be vulnerable, psychosocial factors such as grief, abandonment and fear of being a burden can affect people from every demographic group, as do coercion and undue influence. The Vulnerable Persons Standard protects potentially everyone, by ensuring that physician-assisted death meets the stringent requirements called for by the Supreme Court.

**4. Does the Standard restrict access to physician-assisted death to end-of-life conditions?**

Yes. The Supreme Court of Canada has determined that adults who 'may be vulnerable to committing suicide in a time of weakness' should be protected.

In its Carter decision, the Supreme Court adopted the language introduced by the lower court. The legal phrase "grievous and irremediable" was defined by the lower court in its finding as an "advanced state of weakening capacities", with "no chance of improvement". In granting Gloria Taylor a constitutional exemption from the law prohibiting an assisted death, the trial judge stated that physician-assisted death was justified only where the adult was "terminally ill and near death, and there is no hope of her recovering". The criteria were intentionally restricted to end-of-life conditions with no hope of recovery in order to protect vulnerable persons who have unmet needs for treatment and support.

Therefore, if people are not at the end-of-life with medical conditions that cause enduring and intolerable suffering, then

their request to die must be considered as an expression of their vulnerability – an intolerable level of unmet need that requires response.

**5. Is the Vulnerable Persons Standard consistent with the Supreme Court's decision in the Carter case?**

Yes. The Vulnerable Persons Standard is entirely consistent with the Court's ruling in Carter. In fact it meets the high standard imposed by the Court to protect vulnerable persons from being induced to commit suicide. Constitutional law experts and human rights lawyers who support the Vulnerable Persons Standard agree that adopting the Standard is an appropriate exercise of legislative authority and consistent with the principle of a constitutional dialogue between the Courts and the legislature.

It has been said that the Carter decision establishes the "floor", or minimum standard, which an assisted dying law must meet in Canada. Some have interpreted this to mean that the broad terms utilized in the Court's decision should not be defined and that criteria for providing an assisted death should not restrict an absolute right of access. This interpretation should not stand. Nothing in the Carter decision, or in the Canadian Charter of Rights and Freedoms should be interpreted in such a way as to put vulnerable persons at risk. If the Carter decision establishes a floor, it is a floor upon which must be constructed a robust set of safeguards for the protection of vulnerable persons.

**6. How will it be determined if a patient's condition is "grievous and irremediable"?**

Two physicians, through independent medical assessments and in consultation with the patient, must agree that the medical condition is grievous and irremediable in that it places the person in an "advanced state of weakening capacities", with "no chance of improvement". Both physicians must independently provide a prognosis that the patient is at the end of life.

**7. What is a 'vulnerability assessment' and why is it necessary?**

A vulnerability assessment is an opportunity for appropriately trained health or social service professionals to carefully consider any conditions related to the social determinants of health and psychosocial factors that may underlie or increase a

person's suffering.

Evidence indicates that adults who request physician-assisted death may be motivated by a range of circumstances separate from their end-of-life conditions. These can include an impairment of judgment, fear of losing independence, concern for stress on caregivers, a sense of shame resulting from their condition as well as direct or indirect coercion by others. A person who is disempowered or intimidated by authority figures in their life may also be unduly influenced, for example, by what they think a doctor or a dominant family member wants them to do.

Vulnerability assessments are required to assess whether these or other circumstances are contributing to the patient's desire to die. The assessment process should seek to alleviate these conditions by addressing sources of vulnerability.

An effective, interdisciplinary assessment of physical, psychosocial and existential causes of suffering should be designed to open doors and remove barriers, offering alternative options that might increase a person's resilience and well-being.

**8. Why should consent and authorization processes for physician-assisted death be different from those for other medical procedures?**

There are ethical, medical and legal reasons that maintain an important distinction between providing a physician-assisted death and complying with a patient's request to withhold or withdraw life-sustaining treatment.

The ethical distinction most often cited relates to the intent of the physician who in either case, acts on the instruction of a patient. In the case of physician-assisted death, the intent is to cause death. In the case of withholding or withdrawal of treatment, the intent is to refrain from violating the patient's bodily integrity, consistent with their right not to be touched without prior informed consent.

Important medical distinctions arise in part from questions of when death occurs and how death is caused. Patients who refuse or request withdrawal of life-sustaining treatment may continue living for some time, some enjoying a good quality of life in their final days or months. Regardless of when death comes after withholding or withdrawing life-sustaining treatment,

it comes as a result of the natural course of a medical condition. Directly causing the death of a patient, especially one whose death is not otherwise imminent, is profoundly different from complying with a request to withhold or withdraw treatment and is therefore well outside the current practice of medicine.

Legal distinctions arise in part because physician-assisted death is a specific exemption to the Criminal Code only under very particular circumstances. If the legal requirements are not met (for example, if there is no grievous and irremediable medical condition causing enduring and intolerable suffering), taking another person's life, even with their consent, is a serious crime. For the withholding or withdrawal of treatment, there are no comparable criteria specified in the Criminal Code. In fact, if a physician does NOT comply with a patient's instruction to withdraw or refrain from treatment, the physician will have committed the crime of assault and the tort of battery. On the other hand, in the context of physician-assisted death, if a physician DOES comply with a patient's instruction, a crime will have been committed UNLESS the Carter criteria are met.

As detailed below, this fact signals the requirement for robust safeguards to ensure that legal requirements are met before the administration of an assisted death, consistent with the trial court's reference to a "stringently limited, carefully monitored system of exceptions" to the Criminal Code.

**9. Why is it necessary to involve the Courts, or legally mandated independent decision-making body before proceeding with a physician-hastened death?**

It is important to recognize three distinct stages in the process of physician-assisted death: Medical Evaluation, Legal Determination and Administration.

In the Medical Evaluation phase, a diversity of medical insights and expertise are required. Healthcare professionals work with the patient to assess their medical condition and prognosis, to consider all sources of their suffering and to explore any available medical and social interventions that could alleviate both symptoms and suffering. These processes support a patient to make an informed choice about physician-assisted death.

In the Legal Determination phase, a legal decision must be made. For an exemption to be granted to the Criminal Code

prohibitions against the taking of life, the narrow criteria specified by the Supreme Court of Canada must be met. A judge, tribunal or expert panel authorized to make this judgment must be satisfied that the required medical evaluation phase has been completed, that assessments of a patient's capacity and consent have been properly made, and that possible sources of inducement, coercion or undue influence have not been overlooked.

In the Administration phase, a duly authorized healthcare professional (usually a physician), acting with the authorization of a judge, tribunal or expert panel, provides an assisted death. As a matter of course, and in accordance with the Standard, the patient's capacity and consent must again be verified at the time of administration.

When understood in this way, it becomes clear that the evaluative and administration phases of the assisted-dying process require the expertise of physicians and healthcare professionals. The Legal Determination phase, however, is clearly outside the purview of medicine, and calls for neutrality, legal knowledge and procedural fairness. Decisions made at this phase must address the needs of the person who has made the request, the person or persons who will fulfill the request, and the public interest served by the Criminal Code. For this reason, a formal but expedited process of legally mandated determination is required before proceeding with a physician-assisted death.

**10. Would patients suffering from severe and ongoing mental anguish or psychiatric illness qualify under the Standard?**

If the patient can provide voluntary and capable consent and has an end-of-life condition that is "grievous and irremediable" which has been found by two physicians to cause enduring suffering including mental anguish or psychiatric illness, the patient could be eligible. However, mental anguish or psychiatric illness on its own is not an end-of-life condition and so would not be eligible.

**11. Does the Standard allow minors to access physician-assisted death?**

No. The Supreme Court judgment explicitly limited its declaration to adults who meet all specified criteria for an assisted death. The Standard is entirely consistent with the Court's decision, and ensures that the particular vulnerabilities of

children and youth are respected.

**12. Would persons with developmental, intellectual or cognitive disability qualify under the Standard?**

Developmental, intellectual or cognitive disability on its own is not an end-of-life condition and so would not be eligible.

**13. Why does the Standard not allow for adults to request physician-assisted death through an advance directive?**

The Supreme Court has stated that a person must have the capacity to give free and voluntary consent to a physician-assisted death, based on the experience of enduring and intolerable suffering "in the circumstances of his or her condition". Advance directives have authority only at some undetermined point in the future, after a person is no longer competent to make decisions for him or herself.

A request for physician-assisted death must be motivated by a person's personal and subjective experience of intolerable suffering. Predicting future suffering is unreliable: studies of human psychology indicate that people routinely mis-predict how much they will suffer as a result of future events. When a person no longer has the capacity to decide whether their suffering is so great as to choose physician-assisted death, advance directives would require some other decision-maker to assess that person's experience of suffering. While determining the cause of a person's suffering may be undertaken objectively, determining the amount or quality of a person's suffering can only be done subjectively. To empower others to decide whether a person with cognitive impairments is suffering enough to warrant a physician-assisted death would make too many people vulnerable to abuse and error, especially error based on stigma, stereotype or prejudice.

Advance directives cannot meet the requirement imposed by the Supreme Court: that the person must be experiencing enduring suffering that is intolerable "in the circumstances of his or her condition." Those circumstances, how a person will respond, and the options that might be available at that time cannot be anticipated in advance.

**14. Why does the Standard require that a request for**

**physician-assisted death be referred to judge or an independent expert body?**

Authorization by a judge or independent expert body ensures that the patient's request satisfies the criteria necessary to obtain the legal participation of a physician to assist a person's death.

This authority would verify that vulnerability assessments have been conducted, that two physicians concur with the request and have fulfilled their responsibilities under the law, and that all risks of abuse and error have been minimized to the greatest extent possible.

**15. Would there be a path to appeal the decision of a judge or an independent expert body?**

Yes, patients whose requests are not approved could appeal to the appropriate court of their province or territory.

**16. Is there a model that can be the basis for an independent expert body?**

Yes. Provinces and territories have a variety of arms-length mechanisms to authorize health care decisions, consent, civil committal, substitute decision-making, disclosure of personal health information and mandatory blood testing.

For example, Ontario's Consent and Capacity Board considered over 3,500 applications on these questions in 2014/15, and has a roster of over 120 members who adjudicate on its behalf.

As well, each province and territory has a review board established under the Criminal Code to make placement decisions about individuals found to be not criminally responsible or unfit to stand trial.

These precedents are good models and provide the basis for designing a credible independent authorization system for physician-assisted death in each province and territory.

**17. Does the requirement for independent authorization create an undue burden for persons who are suffering at the end of their lives?**

No. The experience of the other Boards and Tribunals noted above indicates that proceedings can be conducted on an

expedited basis, and with due regard and accommodation for an applicant's fragile condition and circumstances.

**18. Why are communication accommodations and support important?**

Effective communication is essential for all patients facing end-of-life decisions. Successful communication is a two-way process in which messages are correctly and unambiguously understood by both the patient and the physician. If there is any question about the communication process as identified by the physician or the patient, then a neutral, independent professional with expertise in the patient's communication needs must be engaged in order to assess the required communication accommodations and/or to provide direct communication support. Communication accommodations and supports are required if the patient has challenges understanding information provided to them, retaining and weighing the consequences of options as part of the decision-making process and accurately and authentically communicating their decision. Communication accommodations include picture or letter boards, speech-output devices, or communication support from a sign language interpreter (ASL/English or LSQ French), Deafblind intervenor, speech language pathologist, language translator or cultural interpreter.

**19. Is the Standard consistent with international law?**

Yes. In its 2001 review of the report from the Netherlands on the International Covenant on Civil and Political Rights, the Human Rights Committee of the UN expressed concern that assisted suicide and euthanasia in the Netherlands were subject only to "ex-post [facto] control, not being able to prevent the termination of life when the statutory conditions are not fulfilled". In its 2009 report, the Committee repeated that it "remains concerned… [because] although a second physician must give an opinion, a physician can terminate a patient's life without any independent review by a judge or magistrate to guarantee that this decision was not the subject of undue influence or misapprehension." Like the Netherlands, Canada has committed to comply with its obligations under this covenant, which was ratified in 1976.

Canada has also ratified the UN Convention on the Rights of

Persons with Disabilities, including Article 10 on the obligation to protect the inherent right to life of people with disabilities, and Article 16 on the obligation to protect against exploitation and abuse. Canada's compliance with these Articles is now being reviewed by the United Nations, and the compliance of the system for physician-assisted death is expected to be reported on by the UN in 2017.

**20. Who developed this Standard?**

The standard was developed by a group of advisors with expertise in medicine, ethics, law, public policy and needs of vulnerable persons. A full list of the advisers to the Standard is available.

Please note that some advisers who have contributed to the Standard have ethical and moral objections to euthanasia and assisted suicide, but support this Standard in order to help limit the harms and risks these practices present, especially to vulnerable people.

**21. Who endorses this Standard?**

A list of the organizations that have endorsed the Standard is available at www.vps-npv.ca.

Please note that some individuals and organizations that have endorsed the Standard have ethical and moral objections to euthanasia and assisted suicide, but support this Standard in order to help limit the harms and risks these practices present, especially to vulnerable people.

**22. How is the Standard intended to be used?**

The standard is intended as a tool for legislators in Parliament and provincial and territorial legislatures to guide law and policy reform to ensure the system for physician-assisted death is designed to protect vulnerable persons. It is also intended as a resource for civil society and professional organizations committed to help develop and promote robust safeguards that will ensure that vulnerable persons are protected in the system.

**23. Does Canada's MAiD law / Bill C-14 comply with the Vulnerable Persons Standard?**

The Vulnerable Persons Standard established five evidence-

based safeguards and sixteen requirements deemed necessary to protect the lives of people who may be subject to coercion or inducement, or who without adequate supports may decide to request to physician-assistance in dying. Canada's MAiD law fully complies with three of the VPS requirements, partially complies with eight of requirements and does not comply with five of the requirements. See our compliance table on www.vps-npv.ca.

**24. Where can I get more information about this issue?**

For more information, please visit the 'News and Resources' tab on the menu, and follow links to the organizations which have signaled their support for the Vulnerable Persons Standard.