Response to the CPSO's Policy Consultation
The Evangelical Fellowship of Canada

November 28, 2022

The Evangelical Fellowship of Canada (EFC) is the national association of evangelical Christians in Canada. Established in 1964, the EFC provides a national forum for Canada's four million Evangelicals and a constructive voice for biblical principles in life and society.

We are grateful for the opportunity to participate in the CPSO's consultation on its draft policy on MAID and companion resources.

MAID Policy

Cause of death

The draft MAID policy, in provision 11, states that physicians "(a) **must** list the illness, disease, or disability leading to the request for MAID as the cause of death; and (b) **must not** make any reference to MAID or the medications administered on the certificate" of a patient who has had their life ended by MAID. We strongly urge the CPSO to amend this provision.

It is essential that MAID be listed as the cause of death. While it may have been a decision of the Ministry of Health and Long-Term Care, Ministry of Government and Consumer Services and the Office of the Chief Coroner to not list MAID as a cause of death, we urge the CPSO to push back against this decision.

The Medical Certificate of Death has multiple lines for the immediate cause of death, as well as the antecedent causes and other significant conditions. The medical conditions that cause a person's suffering or the grievous and irremediable medical condition that makes a person eligible for MAID should be listed on the certificate of death along with MAID as the immediate cause of death.

The creation of Track 2 for MAID in 2021 means that a person with a disability or illness that would not cause death can apply for MAID. For example, recent media reports describe the situation of Amir Farsoud who suffers from a back injury and depression, but who has clearly stated that his reason for requesting MAID was the expectation of losing his housing.[1] Farsoud's MAID application was approved by one doctor before he received funds to help with housing and withdrew from the pursuit of MAID. There are many other accounts of people with disability or chronic illness applying for MAID due to a lack of affordable housing, treatment or

[1] https://toronto.citynews.ca/2022/10/13/medical-assistance-death-maid-canada/

financial support. It is incongruous and incorrect to list a cause of death as, for example, multiple chemical sensitivity, when the condition does not cause the person's death and when they could have lived for decades longer if death was not brought about via MAID.

Even with patients whose natural death is reasonably foreseeable, it is important to have accurate records on the immediate cause of death. It camouflages the practice of MAID to exclude it from the death certificate, meaning research and public awareness of the practice are incomplete. This is the opposite of open and transparent practice.

This is one critical source of data that will help indicate whether safeguards are being followed. In fact, the Medical Certificate of Death – Form 16 question 20 specifically asks the clinician to specify whether death was due to an accident, suicide or homicide. Given that MAID is a form of physician-assisted suicide or voluntary euthanasia, this fits within the category of questioning in the certificate. It provides information that is useful and informative to track.

The cause of death information provides important information for medical and health research and for statistical purposes. The *Handbook on Medical Certification of Death* published by the Ontario Office of the Registrar General notes that death registration forms, specifically the Medical Certificate of Death, are the basis of "the oldest and most extensive public health surveillance system."[2]

The *Handbook* goes on to state: "These statistical data are used by federal, provincial and local governments, researchers and clinicians, educational institutions and many others for many purposes." The Handbook lists many uses for this data, such as identifying regional differences in death rates, identifying risks associated with external factors, assessing prevention and screening programs, and monitoring trends in public health issues such as suicide.

Many of these areas of research seem especially important given that MAID is a relatively new practice and has inherent risks for people at points of vulnerability. This is especially so with the expansion of eligibility to people who are not dying, and soon, to those with mental illness alone.

We recommend the CPSO require physicians to record MAID as the cause of death, and whether the patient was eligible under Track 1 or Track 2. Further, we recommend physicians be required to record movement of patients from Track 2 to Track 1 with details on the rationale for the change. Not only might this serve to protect patients, but it also improves data collection and sheds light on how MAID decisions are being made.

[2] *Handbook on Medical Certification of Death*, Ontario Office of the Registrar General, August 2010, https://www.publications.gov.on.ca/store/20170501121/Free_Download_Files/016600.pdf

MAID Policy

Voluntariness

In 3(b) of the draft MAID Policy, physicians are instructed that "Where the patient's capacity or voluntariness is in question, physicians **must** conduct and/or refer the patient for a specialized capacity assessment."

It is reasonable to follow up concerns about capacity with a capacity assessment. However, if a physician questions whether a patient is voluntarily requesting MAID, it seems inadequate to merely carry out a capacity assessment. It is possible for a patient who is capable of making a decision to be pressured or coerced into requesting MAID by their relatives or caregivers, healthcare providers or circumstances. There are growing accounts of individuals eligible under Track 2 choosing MAID not because of a desire to end their life, but because of poverty, lack of housing or lack of appropriate supports. As well, high quality palliative care is not universally available, and many treatments and specialists have lengthy waiting lists. Being unable to access treatment and support in a timely way may push patients toward MAID. This seems to be an inadequate guidance for a situation in which patients are particularly vulnerable.

We recommend the CPSO provide further guidance on what to do in cases where a patient may be pressured or under duress to apply for MAID in its *Advice to the Profession: MAID*.

Advice to the Profession: MAID

Discussions about MAID must be patient-initiated

The companion resource *Advice to the Profession: MAID* says physicians "will have to use their professional judgment to determine if, when, and how to discuss MAID with their patients."

We urge the CPSO to instruct physicians that discussions about MAID must be patient-initiated. We recommend the CPSO follow the example of New Zealand and Victoria, Australia, which explicitly prohibit doctors from bringing up assisted dying with their patients.

Doctors are in a position of authority, and ideally, trust. Raising MAID as an option suggests to a patient that the clinician sees their life as not worth living, or that ending their life is something worth considering. The suggestion that MAID is an option is likely to be taken as a recommendation. This cannot be.

The CPSO *Advice to the Profession: MAID* refers physicians to the Canadian Association of MAID Assessors and Providers' clinical guidance document, *Bringing up MAID as a clinical care option*. The CAMAP document suggests that clinicians have a professional obligation to bring up MAID as an option for patients when it is medically-relevant and they are likely eligible for MAID.

We disagree strongly that any physician has a professional obligation to initiate conversations about MAID with a patient. Doing so is significantly different than responding to a patient inquiry about eligibility for MAID.

Further, given the reality of medical ableism, clinicians may believe patients should consider MAID due to their disability or chronic illness when patients do not feel they are suffering and are not contemplating ending their life.

Although it was not in a clinical context, the recent incident in which a Veterans Affairs Canada service agent brought up MAID to a combat veteran seeking treatment for PTSD and brain injury is instructive. In a conversation about obtaining treatment, the veteran was deeply disturbed when a service agent proposed MAID to him. The unprompted suggestion of MAID has disrupted the veteran's progress and been harmful to his progress and his family's well-being, according to media reports.[3] Seeking treatment and healing, but instead being offered death by the one designated to provide care can cause feelings of betrayal and great distress.

It is in the public interest to protect patients against the possibility of subtle or overt pressure to pursue MAID. To ensure requests for MAID are voluntary and not influenced by the power imbalance in physician-patient relationships, **discussions about and requests for MAID must only be patient-initiated.** This is critical now and will become even more so when eligibility is extended to persons with mental illness alone.

We recommend the CPSO amend its policy to instruct physicians that conversations about MAID must be patient-initiated.

Advice to the Profession: MAID

Determining reasonably foreseeable natural death

In *Advice to the Profession: MAID*, there is a discussion on how physicians can determine whether a patient's natural death is reasonably foreseeable. The draft Advice offers the following as guidance: "If the patient expresses an intent to refuse treatments that would prolong their life and they will inevitably die without those treatments, then it is likely that the patient will meet the threshold for a 'reasonably foreseeable natural death,' footnoting CAMAP guidelines and expert evidence in *Lamb v. Canada* as the source.

Not only has this definition of reasonably foreseeable natural death not been tested in court, it widens eligibility to Track 1 MAID far beyond what legislators initially intended and what the Canadian public is likely to accept. If a person with diabetes need only express the intention to stop using insulin or a person with asthma to stop using an inhaler, according to this guidance, they could be eligible for Track 1 MAID without the requirement of a reflection period.

In addition, the document points to 'other guidance' on the meaning of "reasonably foreseeable natural death" that states, "If the MAID provider/assessor can reasonably predict when or how the patient will die, then it is likely enough to establish that the patient will have a "reasonably foreseeable natural death." A physician may reasonably predict that a patient with high cholesterol may die of a heart attack or stroke without that person's natural death being

[3] https://globalnews.ca/news/9064116/veteran-assisted-dying-reaction/

reasonably foreseeable. Predicting when or how a patient will die is not a high enough bar to move someone into Track 1 MAID with its very limited safeguards.

We recommend the CPSO delete lines 181-188 from *Advice to the Profession: MAID*.

Human Rights in the Provision of Health Services
Health services that conflict with physicians' conscience or religious beliefs
The *Professional Obligations and Human Rights* policy currently in effect that the CPSO is planning to replace begins the section on Conscience or Religious Beliefs with the statement that, "The College recognizes that physicians have the right to limit the health services they provide for reasons of conscience or religion." The current policy also mentions that physicians are not prevented from "limiting the health services they provide for legitimate reasons (for instance, because the care is … contrary to their conscience or religious beliefs.)"

The new draft policy proposes dropping the reference to physician's freedom of conscience and religion. It also omits the reference to conscience or religious belief as a legitimate reason for physicians limiting the health services they provide.

CPSO policies must not erase the mention of *Charter*-protected freedoms of conscience and religion. These are fundamental freedoms that CPSO policies should recognize and support, even though the court has found that these freedoms must be balanced with patients' right to access care.

Conscience is rooted in the convictions and judgment of the individual physician. It is not the same for all physicians, even among those whose convictions are religiously informed.

Even medical professionals who don't object to euthanasia in principle may feel they cannot end the life of a patient who still has decades to live, or whose request is motivated by despair over inadequate living conditions or lack of support.

The draft policy proposes adding new requirements to the effective referral process. This policy proposes the conscientious objector must take the additional steps of confirming a patient requesting MAID has been connected with a non-objecting, available and accessible health-care professional or agency. It also requires the conscientious objector take further action to provide an effective referral if the patient was not connected. We object to this new requirement. As noted above, given the doctor-patient power imbalance, we believe it is essential that conversations and steps to pursue MAID be patient-initiated and directed. A physician should never be the one to initiate a conversation on MAID.

A patient who is unable to connect with a non-objecting physician or agency can inform their physician and ask again for an effective referral. The onus must not be put on a physician to raise the topic of MAID and confirm a patient was connected. These are fundamentally different propositions.

Protecting physicians' conscience benefits patients as well. It fosters trust and open, honest communication. It allows patients to find a doctor whose beliefs accord with their own, whether they seek a doctor who supports MAID or one who does not carry it out.

The Council of Canadians with Disabilities clearly advocates for robust conscience protection for Ontario healthcare professionals so that people with disabilities are able to find doctors they can trust as allies:

> Given the ubiquity of medical ableism, it is of utmost importance that physicians and other healthcare providers whose views of the quality and worth of lives lived with disability differ from the majority be afforded robust protection of their conscience rights. People with disabilities need to be able to find doctors and other healthcare providers who they know will fight for their lives when necessary. Without legal protection of the conscience rights of healthcare professionals, this will not be possible. A failure to enact legislation to protect the conscience rights of healthcare professionals would thus leave thousands of Ontarians with disabilities without recourse to healthcare professionals who they can trust to serve as allies against the ubiquity of medical ableism that devalues and endangers their lives.[4]

All Ontarians would benefit from the ability to find physicians whose philosophy of care and convictions align with their own.

[4] http://policyconsult.cpso.on.ca/wp-content/uploads/2021/04/Council-of-Canadians-with-Disabilities-Redacted.pdf