MAXIM INSTITUTE

SUBMISSION TO PUBLIC CONSULTATION FOR THE REVIEW OF THE END OF LIFE CHOICE ACT (2019)

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INTRODUCTION

Thank you for the opportunity to submit this submission to the public consultation for the review of the End of Life Choice Act (2019).

My name is Maryanne Spurdle, and I'm a researcher at Maxim Institute. Maxim Institute believes the End of Life Choice Act lacks sufficient safeguards to protect vulnerable individuals from inaccurate terminal diagnoses, coercion, and inadequate mental health evaluations. Research shows terminal diagnoses predicting a lifespan beyond two weeks are often inaccurate, undermining the Act's eligibility criteria. Additionally, the low rate of psychiatric referrals indicates a troubling reliance on medical professionals without mental health training. Safeguards against coercion are weak and subjective, as most applications are approved in less than two weeks, leaving little time to detect undue pressure.

Safeguards

Do you think the Act provides sufficient safeguards to ensure that people only receive assisted dying if they qualify?

No.

Even medical professionals cannot predict with high levels of accuracy if someone has fewer than six months to live. In fact, predictions of "weeks" or "months" to live are accurate only about 32% of the time, according to PMC Palliative Care. The accuracy rate never climbs higher than 74%, and that is when the timeframe is two weeks or less. If we were to take the criteria of terminal diagnosis seriously, we wouldn't consider allowing anyone who is predicted to live longer than a few weeks to be eligible for assisted suicide. https://doi.org/10.1186/s12904-023-01155-y

The fact that few applicants have been referred to psychiatrists indicates that medical professionals who have not had mental health training consider themselves qualified to make judgments on patients' mental health. The low referral rate is a clear sign that psychiatric evaluation should be required, not at the discretion of an unqualified medical professional, for patients to be served by this safeguard.

Decades of evidence inform contemporary norms for talking about suicide. Professional media refrains from reporting details of individual suicides and methods of death because suicide contagion is a real thing: once shared, the idea lodges in people's minds and some who would not otherwise have taken their own lives then do.

While the intent of the Act is that medical professionals cannot initiate conversations about assisted suicide, many still do. The Act should include clear disincentives for those who are, in essence, increasing their patients' risk of suicide.

The safeguards against coercion are weak and highly subjective. Most applications take little more than two weeks to be approved—not enough time to begin finding out if an elderly person has experienced undue pressure. Even Todd Stephenson admitted that "we can never completely know" if someone has experienced coercion. While he may have meant that we shouldn't try too hard to ensure no coercion exists for the sake of those who are vulnerable, Maxim's position is that we should avoid shortcuts simply because they benefit those who are not vulnerable.

Do you think any changes are needed to the safeguards provided through the Act?

Yes. Given the great lack of certainty for terminal diagnoses with time frames greater than two weeks and the fact that approximately two-thirds of diagnoses are inaccurate when the time frame is six months, this criteria should have a cutoff of no more than a month.

Process to receive assisted dying

Do you think any changes are needed to the process to apply for and receive assisted dying?

The date and time for administration, clause 18, should include a minimum time for the applicant to consider their decision. Where this is legal overseas, these periods exist. Once more, such provision for those who are vulnerable—and may find themselves in a better state of mind than a week or two earlier—is worth including even if it extends the wait time for those who aren't vulnerable.

Practitioners providing assisted dying

Do you think changes should be made to the requirements for medical practitioners and nurse practitioners to provide parts of the assisted dying process?

No medical or nursing staff should be compelled by law or employment agreements to take part in assisted suicide or refer a patient for assisted suicide. The psychological, emotional, and (for many) spiritual aspects of ending a human life are so profound that freedom of conscience must be allowed to determine whether one participates or not.

Oversight of assisted dying

Do you think changes are required to the roles and responsibilities of the entities established under the Act to oversee assisted dying?

Yes. When the End of Life Review Committee is not complete and serving its necessary function—as was the case for much of the past year—new approvals should be halted until oversight returns. Otherwise, a review of all deaths will be seen as optional instead of an essential safeguard against unjust loss of life.

Alignment with the wider health system

Do you think the assisted dying process aligns with other parts of the health system?

No. It allows patients to bypass the psychiatric care available and severely undermines the place of palliative care.

The concerns that this will reduce support for palliative care, which too few people have good access to as it is, are not unfounded. Researcher David Farrar pointed out that it costs the taxpayer $1,087.20, "so a total cost of say $500,000 a year compared to the cost of palliative care of $186 million a year. You could even argue that euthanasia reduces the cost of palliative care."

Of course, it does not literally reduce the cost of palliative care; it reduces the lifespan of those who would otherwise need it. Those who have the most difficulty accessing or affording palliative care will be those most likely to be persuaded to choose assisted suicide.

Is there anything that could be improved?

The initial lack of oversight from the End of Life Review Committee and transparency in its operation should be addressed. Rather than assume everything is operating well, every effort should be made to ensure it is and publish findings.

Other feedback

Do you have any other feedback related to the Act?

An independent review of this Act's impact would provide better assurance that it is not disadvantaging vulnerable people than one conducted by the Ministry of Health itself.