Vulnerable Persons Standard

Norme sur la protection des personnes vulnérables

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Requirements	Safeguards
1. **Equal Protection for Vulnerable Persons** The right to the equal protection and equal benefit of the law without discrimination must be preserved for all. Amendments to the Criminal Code concerning physician-assisted death must not perpetuate disadvantage or contribute to social vulnerability.	▪ The Criminal Code exemption includes a preamble affirming that all lives, however they are lived, have inherent dignity and are worthy of respect. ▪ The operational implementation of the Criminal Code exemption will be carefully regulated and publicly reported. ▪ Independent research into the social impacts of Canada's assisted death policies will be promoted, financially supported and publicly reported. Any adverse impacts of the law which directly or indirectly cause harm or disadvantage to Canadians, or to Canada's social fabric, will be identified and addressed without delay. ▪ The provision of palliative care options for all Canadians with end-of-life conditions will be prioritized and the impact of the practice of physician-assisted death will be subject to ongoing and rigorous attention.
2. **End-of-life Condition** Physician-assisted death is only authorized for end-of-life conditions for adults in a state of advanced weakening capacities with no chance of improvement and who have enduring and intolerable suffering as a result of a grievous and irremediable medical condition.	▪ Two physicians must independently assess the medical condition as grievous and irremediable, meaning an advanced state of weakening capacities, with no chance of improvement, and at the end of life. ▪ The physicians who make these threshold assessments must have specific expertise in relation to the person's medical condition as well as the range of appropriate care options. They must have met with the patient and diligently explored their request.
3. **Voluntary and Capable Consent** Voluntariness, non-ambivalence and decisional capacity are required to request and consent to an assisted death, including immediately prior to death.	▪ In evaluating the request, physicians must separately attest that the person: 1) has made the request independently, free of undue influence or coercion; 2) has capacity to make the request; 3) is informed and understands all alternatives; and, 4) has been supported to pursue any acceptable alternatives, including palliative care. ▪ A physician must attest at the time when assistance is provided that the person has the capacity to give consent, and that consent is voluntary and non-ambivalent. ▪ In all discussions related to physician-assisted death with the patient, neutral, independent and professional interpretation services, including ASL/LSQ, must be provided as required. ▪ The use of advance directives to authorize physician-assisted death is prohibited.
4. **Assessment of Suffering and Vulnerability** A request for physician-assisted death requires a careful exploration of the causes of a patient's suffering as well as any inducements that may arise from psychosocial or non-medical conditions and circumstance.	▪ Two physicians must, after consultation with members of the patient's extended health care team, attest that the person's subjective experience of enduring and intolerable suffering is the direct and substantial result of a grievous and irremediable medical condition. ▪ If psychosocial factors such as grief, loneliness, stigma, and shame or social conditions such as a lack of needed supports for the person and their caregivers are motivating the patient's request, these will be actively explored. Every effort must be made, through palliative care and other means, to alleviate their impact upon the person's suffering.
5. **Arms-Length Authorization** The request for physician-assisted death is subject to an expedited prior review and authorization by a judge or independent body with expertise in the fields of health care, ethics and law. The law, the eligibility assessment process, and mechanisms for arms-length prior review and authorization are both transparent and consistent across Canada.	▪ Every request along with all related clinical assessments are reviewed by a judge or an independent expert body with authority to approve or deny the request for exemption from the prohibitions on assisted death, or to request more information prior to making a determination. ▪ Decisions will be made on an expedited basis, appropriate to the person's life expectancy prognosis and with a degree of formality and expertise appropriate to the circumstance. ▪ Reasons will be recorded and reported for each decision. ▪ Legal provisions for exemption to the prohibitions on assisted death are in the Criminal Code to ensure pan-Canadian consistency, including: definitions, criteria for access, requirements of vulnerability assessments, and terms for independent prior review in each province or territory.

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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. 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.

4. 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.

5. 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.

6. How will it be determined whether the person requesting physician-assisted death is vulnerable to suffering caused by factors other than their medical condition?

Together with the patient’s physicians, an interdisciplinary health team will provide expertise in physical, psychosocial and spiritual causes of suffering, treatment and support alternatives, and be attuned to the risks of inducement and coercion as they complete a comprehensive vulnerability assessment.

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 vulnerability assessment and evaluation should be designed to open doors and remove barriers, offering alternative options that might increase a person's resilience and well-being.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. Why is the availability of interpretation services important?

It is essential for patients facing end-of-life conditions to fully understand and converse about the options available to them. Patients must have access to neutral, independent and professional interpreter services, including ASL/English, LSQ/French as well as Cultural interpretation and other communication accommodations to support decision-making.

17. Is the Standard consistent with international law?

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.

18. 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 advisors to the Standard is available at www.vps-npv.ca.

Please note that some advisors 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.

19. 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.

20. 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.

21. 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.

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Advisors to the Vulnerable Persons Standard

The following Advisors to the Vulnerable Persons Standard have contributed their invaluable insights and expertise to this initiative, either through active participation in authorship and review, or through thoughtful endorsement of the Standard and its safeguards framework. Although some of these individuals have ethical and moral objections to euthanasia and assisted suicide, they support the Standard in order to limit the harms and risks that these practices present, especially to vulnerable people.

Affiliations are indicated for information purposes only and do not necessarily represent organizational endorsement.

— As of February 29, 2016

1. **Michael Bach,** PhD
   Executive Vice President, Canadian Association for Community Living
   Managing Director, IRIS–Institute for Research & Development on Inclusion and Society
   Adjunct Professor, Disability Studies, Ryerson University

2. **David Baker,** LLB
   Barrister and Solicitor, Bakerlaw

3. **Dr. Althea Burrell,** BASc, MD, FRCP(C)
   Staff Respirologist, Markham Stouffville Hospital

4. **Dr. Sharon Chapman,** MBBCh, CCFP
   Family Medicine; Family Physician, Vancouver, BC
   Hospice-Based Palliative Care Physician, St. Michael's Hospice, Burnaby, BC

5. **Dr. Sherry Chan,** MD, CCFP
   General Practitioner in Oncology, BC Cancer Agency, Vancouver, BC
   Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

6. **Dr. Luke Chen,** MD, FRCPC, MMEd
   Residency Program Director and Clinical Assistant Professor, Division of Hematology, Vancouver General Hospital and University of British Columbia
   Hematologist, Vancouver, BC

7. **Dr. Harvey Max Chochinov,** OC, OM, MD, PhD, FRCPC, FRSC
   Distinguished Professor of Psychiatry, University of Manitoba
   Canada Research Chair in Palliative Care
   Director, Manitoba Palliative Care Research Unit, CancerCare Manitoba
   Chair, Canadian Virtual Hospice

8. **Dr. Joyce Choi,** MD, CCFP
   Family Physician, Vancouver, BC
   Staff Physician, Short Term Assessment & Treatment Centre, Vancouver General Hospital, Vancouver, BC
   Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

9. **Dr. Margaret Cottle,** MD, CCFP (Palliative Care)
   Palliative Care Physician, Burnaby Palliative Care Program, Fraser Health Authority, Burnaby, BC and Vancouver Coastal Health Authority, Vancouver, BC
   Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

10. **Jim Derksen,** LLD. (Hon.)
    Senior Advisor, Council of Canadians with Disabilities
    Special Advisor – Vulnerable Persons and End of Life Care Initiative (Completed)
    Premier's Advisory Council on Education, Poverty and Citizenship in Manitoba

11. **Dr. Ed Dubland**, MD, AAHPMc, MCFP (Palliative Care)
    Family Physician, Collingwood Medical Clinic, Vancouver, BC
    Palliative Medicine, Medical Coordinator, Burnaby Palliative Care Program, Fraser Health Authority, Burnaby, BC
    Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

12. **Al Etmanski,** OC
    Co-Founder of PLAN – Planned Lifetime Advocacy Networks
    Co-founder of Social innovation Generation (SiG) and BC Partners for Social Impact

13. **Dr. Catherine Ferrier** MD, CCFP, FCFP
    Division of Geriatric Medicine, McGill University Health Centre
    Assistant Professor, Department of Family Medicine, McGill University

14. **Catherine Frazee,** OC, D.Litt., LLD. (Hon.)
    Professor Emerita, Ryerson University School of Disability Studies

15. **Dr. Rose Geist**
    Deputy Chief of Staff and Chief of Mental Health Systems, Trillium Health Centre
    Associate Professor of Psychiatry (Child and Adolescent Division), University of Toronto

16. **Dr. Peter D. Golin,** MD
    Family Physician, Vancouver, BC

17. Dr. Philip J. Hanam, MD, CCFP
    Family Medicine
    Family Physician, Vancouver, BC

18. **Dr. Stephen W. Hwang,** MD, MPH, FRCPC

Professor of Medicine and Director, Division of General Internal Medicine, University of Toronto
Director, Centre for Research on Inner City Health, Li Ka Shing Knowledge Institute of St. Michael's Hospital, Toronto
Chair in Homelessness, Housing and Health, and Staff Physician, St. Michael's Hospital and the University of Toronto

19. **Dr. Will Johnston,** MD, MCFP
    Clinical Assistant Professor, Department of Family Practice, University of British Columbia, Vancouver, BC

20. **Dr. Nuala Kenny,** OC, MD, FRCP(C)
    Professor Emeritus, Dalhousie University and Former Member, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying

21. **Lana Kerzner,** LLB
    Barrister and Solicitor, Toronto
    Lecturer in Disability and Law, School of Disability Studies, Ryerson University

22. **Robert Lattanzio,** LLB BCL
    Executive Director, ARCH Disability Law Centre

23. **Trudo Lemmens** (LicJur, LLM bioethics, DCL)
    Professor and Scholl Chair in Health Law and Policy
    Faculty of Law, University of Toronto

24. **Dr. Renata Leong,** MD.,cM, MHSc, CCFP, FCFP
    Staff Physician, Department of Family and Community Medicine, St. Michael's Hospital
    Assistant Professor, Department of Family and Community Medicine, University of Toronto

25. **Dr. Constant H. Leung,** MD, CCFP, FCFP
    Family Physician, Collingwood Medical Clinic, Vancouver, BC
    Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

26. **Dr. Wi-Guan Lim,** MD
    Family Physician, Vancouver, BC

27. **Brian L. Mishara,** Ph.D
    Directeur, Centre de recherche et d'intervention sur le suicide et l'euthanasie
    Professeur, Département de psychologie, Université du Québec à Montréal

28. **Dr. Balfour M. Mount,** OC, OQ, MD, FRCS(C), LLD
    Professor and Emeritus Flanders Chair of Palliative Medicine, McGill University

29. **Wendall Nicholas**
    Chair, Wabanaki Council on Disability

30. **Dianne Pothier**
    Professor Emeritus, Schulich School of Law, Dalhousie University

31. **Michael J. Prince, PhD**
    Landsdowne Professor of Social Policy, University of Victoria

32. **Dean Richert,** LLB
    Barrister and Solicitor
    Co-Chair, End of Life Ethics Committee, Council of Canadians with Disabilities
    Associate, Duboff Edwards Haight & Schachter Law Corporation Member

33. **Mary Shariff,** BSc, LLB, LLM, PhD
    Associate Dean Academic, JD Program, University of Manitoba
    Associate Professor, Faculty of Law, University of Manitoba

34. **Margaret Somerville** AM, FRSC, DCL
    Professor and Founding Director, Centre for Medicine, Ethics and Law
    Samuel Gale Chair in Law, McGill Centre for Medicine, Ethics and Law

35. **C. Tess Sheldon,** MSc, JD, LLM, PhD
    Staff Lawyer, ARCH Disability Law Centre
    Adjunct Professor, Faculty of Law, University of Toronto
    Contract lecturer, Faculty of Law, Lakehead University

36. **Timothy Stainton,** BSW, MSW, PhD
    Director and Professor, School of Social Work, University of British Columbia
    Director of the Centre for Inclusion and Citizenship, UBC

37. **Dr. William F. Sullivan**, MD, CCFP, PhD, FCFP.
    Family Physician, St. Michael's Hospital and Surrey Place Centre, Toronto
    Associate Professor, Department of Family and Community Medicine, University of Toronto

38. Donna Thompson
    Disability and family caregiving activist, consultant and author
    Board member, NeuroDevNet, a Canadian Network of Centres of Excellence
    Consultant to Saint Elizabeth Health Care, the Children's Hospital of Eastern Ontario

39. **Dr. Jennifer Y. Tong,** MD, CCFP
    Family Physician,Vancouver, BC
    Clinical Instructor, Department of Family Practice, University of British Columbia, Vancouver, BC

40. **Dr. David Unger,** MSc, MD, CCFP, FCFP
    Physician and Ethicist
    Director of Ethics, Providence Health Care, Vancouver

41. **Dr. Eric Wasylenko,** MD, BSc, MHSc (Bioethics)
    Provincial Medical Advisor, Advance Care Planning / Goals of Care Designation Initiative Alberta Health Services
    Clinical Lecturer, John Dossetor Health Ethics Centre, University of Alberta

42. Rhonda Wiebe
    Co-Chair, End of Life Ethics Committee, Council of Canadians with Disabilities
    Member, Manitoba League of Persons with Disabilities