



Alberta Health

WHAT WE HEARD: MEDICAL ASSISTANCE IN DYING

May 27, 2016

Contents

Introduction

Summary of feedback

- Eligibility
- Protecting the vulnerable
- Administration of medical assistance in dying
- Conscientious objection
- Reporting and monitoring
- Palliative care

Other

Next steps

Appendices

- Survey Results
- Submissions

Introduction

The Supreme Court of Canada has ruled that medical assistance in dying (physician-assisted death) will become legal in Canada on June 6, 2016. By that date, Alberta must be prepared to provide access to this procedure.

The Supreme Court's ruling has created broad and sensitive questions that the Government of Alberta needs to consider in regulating the delivery of medical assistance in dying. While the federal government has some responsibility for health care, the provinces and territories are responsible for the delivery of health care services and the regulation of health professions.

To help determine the best way to protect patients, families, health care providers and our most vulnerable, the Government of Alberta set up an MLA Consultation Panel to gather input from Albertans. Panel members were Associate Minister of Health Brandy Payne and MLAs Dr. Bob Turner and Dr. David Swann. They solicited input through an online survey, written submissions, and meetings with stakeholders.

The online survey generated a total of 15,000 survey responses¹ between February 29 and March 31, 2016. Written submissions were received from 31 organizations, representing health care and health care professionals, religious groups, the legal profession, academia, and voluntary health organizations. Another 31 individuals either wrote or emailed to express their opinion. The MLA Consultation Panel met with eight stakeholder groups, including those representing Indigenous peoples, physicians and medical ethicists. Members of different Indigenous groups in Alberta shared valuable input gathered from consultation with elders, community members, and those with lived experience. Their input helped the Panel to understand the Indigenous worldview on this issue, which contributed to this entire document.

The government will consider all public and organizational input as it puts together its regulatory framework. Through Alberta Health, it will work with Alberta Health Services (AHS), the College of Physicians and Surgeons of Alberta (CPSA) and other health care providers to develop these measures, as well as related policies and practices. It will also continue to work with other provinces and territories and with the federal government,² which is responsible for legalizing medical assistance in dying in the *Criminal Code*.

¹ Survey results do not necessarily reflect general public opinion, only the opinion of those who responded to the survey.

² It should be noted that at the time of this writing, the federal government has introduced amendments to the *Criminal Code* dealing with this issue. In brief, the amendments limit medical assistance in dying to mentally competent adults, age 18 or older whose death is "reasonably foreseeable."

Summary of feedback

While there were differences of opinion amongst respondents, feedback generally fell into six areas: eligibility; protection of the vulnerable; administration of medical assistance in dying; conscientious objection; monitoring and reporting; and palliative care.

Many of the letters and comments from individuals came from a place of experience with dying and offered opinions both in favour of and against medical assistance in dying. All were heartfelt, and the MLA Consultation Panel appreciates their depth and generosity of spirit.

It should be noted that a number of respondents called on the provincial government to do nothing to enable the delivery of medical assistance in dying in Alberta. However, the Supreme Court has ruled it will be legal as of June 6 whether governments (federal and provincial-territorial) regulate it or not. It would, therefore, be irresponsible not to align our framework with the Supreme Court decision.

Eligibility

The Supreme Court decision limits access to medical assistance in dying to “competent adults.” The federal government recently introduced legislation that limits medical assistance in dying to mentally competent adults, age 18 or older, whose death is “reasonably foreseeable.” It does not allow for mature minors, advance directives or access to people for whom mental illness is the sole underlying medical condition.

From the survey

Over half of survey respondents – 54 per cent – said someone younger than 18 years of age should be eligible as long as they are mature and competent enough to understand the nature of the request. The remainder said a person should be at least 18 years of age or had no opinion.

Slightly more than 70 per cent said that applicants must be competent when they make a request, but they may lose competence before the end or before they reach intolerable suffering.

Age

Those making submissions favoured a cautious approach to the issue of minors accessing medical assistance in dying. Most suggested to develop policy narrowly, with room to make changes only after further study and evaluation. Some felt it was wrong to prevent minors from accessing the procedure, and they recommended the establishment of national standards to ensure minors are competent enough to understand the nature of the request and its consequences.

Should minors qualify, one submission suggested assessment of competency be left to the parents and the immediate clinical team with recourse to the courts. Another suggested that a court-appointed guardian determine consent:

- “Children should not be excluded from relief from irremediable grievous suffering. The consent for physician-assisted death for a minor should come from a court-appointed

guardian, with the same requirement for two medical certificates as would exist for adults.” – Letter from Albertan

Organizations that regularly deal with young people expressed concern that legalizing medical assistance in dying could have the unintended effect of “normalizing” suicide. They noted that suicide is one of the leading causes of death of people between the ages of 15 to 24:

- “We acknowledge that most students at risk do not and likely will not in future have need of the assistance of a physician to take their own lives; however, we contend that legalizing physician-assisted death will contribute to a perception that suicide is an acceptable response to difficult life situations.” – Submission from St. Joseph’s College, University of Alberta

Many Albertans clearly opposed any consideration of extending medical assistance in dying to minors:

- “The idea that mature minors would be given physician-assisted death is incredible. We are struggling as a society to combat the negative messages that contribute to suicide in our youth, like bullying, while at the same time, we are promoting death by physicians as being a viable option. How confusing for young people, their parents, and for the work that so many organizations are doing to bring hope to struggling youth today.” – Letter from Albertan

Mental capacity

All submissions agreed that for a request to be valid, the applicant must have completed it while cognitively competent enough to make that decision. Submissions recommended stringent assessments to confirm the applicant is able to fully understand the nature and consequences of the request.

Submissions recommended a variety of ways of conducting assessments, including:

- Establish an “end-of-life” care team consisting of four members – a physician, a psychiatrist or psychologist, a social worker, and a spiritual care provider – to support informed decision-making.
- Employ staff trained in psychosocial end-of-life assessments, probably social workers over psychologists.
- Require certification by a physician that the person is ill and by two other people that the person is competent.

There were differences of opinion as to whether an individual must still be competent when medical assistance in dying is administered:

- “The person must be mentally competent at the time they make the request, and the doctor may fulfill the request even if the person loses competence before the end.” – Letter from Albertan
- “The patient must remain competent to the end.” – Letter from Albertan
- “To be eligible, a patient must either be competent at time of death or have completed an advance request for a physician-assisted death. In order for a request to be considered valid,

the patient must have completed it while they were competent and had, at the time of request, a diagnosis for a medical condition that is or may become grievous or irremediable.”
– Submission from Dying with Dignity Canada

Related to advance directives, most submissions recommended a cautious approach to their implementation. Both physicians and Indigenous contributors predicted difficulties interpreting advance directives could lead to family conflicts. It was noted that there could be challenges in terms of legalizing the use of a proxy, as well as charges of involuntary euthanasia.

Mental Illness

All submissions agreed that special cautions are needed for those with mental health and addictions. Because these conditions may potentially impair judgement, understanding, and appreciation of the consequences of their actions, it may not be possible to establish a person’s ability to make an autonomous decision.

Secondly, concerns were expressed about remediation – the ability of those with a mental illness or an addiction to get better. It was noted that most mental health workers believe that irremediable cases are rare. One submission offered that in many cases the stigma associated with mental illness can cause greater suffering than the mental illness itself and worried this could contribute to a request for medical assistance in dying.

Generally, those making submissions felt that policy-makers need more time to work through these issues with mental health patients, their families, provider groups and mental health advocacy groups. Should medical assistance in dying be made available to those with mental illness, it was suggested at least one of the assessing physicians be a psychiatrist.

- “What is needed in Alberta for all vulnerable people, including those with mental illness, is not legalized euthanasia or assisted suicide, but rather, a serious commitment to treat them.”
– Submission from the Catholic Bishops of Alberta
- “A key issue is that depression can significantly affect a person’s decision to request physician-assisted death but depression is not always recognized. Even with psychiatric expertise and experience, the identification of depression and its influence on an individual’s decision-making capacity can be challenging.” – Submission from the University of Alberta Faculty of Nursing

Protecting the Vulnerable

Of paramount concern to all involved is how we protect vulnerable members of our populations. What safeguards should be in place? Should there be a period of reflection? The federal government recently introduced legislation that provides some protections for the vulnerable. It says requests must be made in writing and signed by the patient or someone else on their behalf, and must be witnessed by two independent individuals. Two independent medical opinions are then required followed by a 10-day period of reflection between request and procedure. If both practitioners agree that the person's death or loss of capacity is imminent, a shorter time frame will be allowed.

From the survey

Sixty per cent of respondents to the online survey believed the safeguards proposed by the College of Physicians and Surgeons of Alberta (CPSA) are sufficient (see sidebar). Twenty-one per cent believe more safeguards are needed, and almost 15 per cent said the safeguards are too onerous.

Over 80 per cent of survey respondents believed there should be a period of reflection, although whether it is defined or not may vary based on individual circumstances. There was no clear consensus on how long is best, but almost half of respondents favoured a period of reflection of 14 days or less.

Safeguards

Most submissions addressing this issue believed the CPSA safeguards are appropriate, but more needs to be done to ensure coordinated mental health, end-of-life and palliative care services and approaches are integrated into all practice settings and available throughout the province. Submissions further suggested that there is a need for more support services – health, housing and financial – for those considered vulnerable. Unmet needs should not contribute to a person's decision to pursue medical assistance in dying:

- “I am well aware that autonomy has become the cardinal ethical principle in Canadian society. I would, nevertheless, vigorously contend that, until vulnerable Albertans – particularly those with disabilities – have unrestricted access to the supports they need to live where and how they want, the notion that providing unrestricted access to physician-assisted suicide will suddenly confer autonomy on them is not only farcical, but tragic.” – Letter from disabled writer and academic
- “We are concerned about the lack of mention of the need for increased access to a continuum of appropriate, high quality housing and health care supports for those living with severe and complex disabling chronic diseases . . . it is crucial that easy access to these

CPSA Safeguards

The CPSA recommends several safeguards to protect the vulnerable:

- The patient must be made aware of all medical options.
- Two doctors must meet the criteria set by the Supreme Court.
- Any questions about mental state must be referred to a psychiatrist or a psychologist.
- Two people must witness the patient's request but must not be a relative or heir, the physician, or the owner, operator or employee of a health facility where the patient is receiving treatment.
- The patient must be advised at each step that they may change their mind, including just before the procedure.

supports exists alongside access to physician-assisted death.” – Submission from the Multiple Sclerosis Society of Canada

Some submissions suggested the Alberta government adopt the Vulnerable Persons Standard³ for those considering medical assistance in dying. The standard, designed by a group of ethicists, medical professionals, lawyers and advocates, proposes a number of evidence-based requirements and safeguards to protect the lives of vulnerable Canadians.

In stakeholder meetings, Indigenous contributors said safeguards must be in place to ensure those who apply for medical assistance in dying are doing so of their own free will. For example, someone with personal and financial pressures may request the procedure on behalf of a family member. Should the application be granted, the heir can assume the property and finances of the deceased. Another individual raised the issue of organ donation, suggesting there could be increased pressure to submit to medical assistance in dying if an organ is needed by a family member. It was recommended that the assessment process build in ways to ensure that an individual’s motivation for seeking the procedure is sound, and that it doesn’t derive from a sense of being a burden or an inconvenience to others.

Reflection

Most individuals making submissions agreed with survey respondents that any period of reflection needs to be flexible and determined on a case-by-case basis, depending on the patient’s condition and the progression of his or her disease or disability. For the few that suggested timelines, the recommended reflection period ranged from less than seven days to more than 90 days between requests.

- “The reflection period may not be short enough based on the experience with my grandparents who have passed with cancer. It was quicker than the seven days and I am almost certain one of my grandparents wanted this (medical assistance in dying) at the time and it was unavailable.” – Comment from survey respondent
- “There should be a minimal cooling off period where the patient can reflect upon his or her request, and then meet a second time with an ethics board.” – Comment from survey respondent

³ <http://www.vps-npv.ca/readthestandard/>

Administration of medical assistance in dying

Should patients be allowed to administer the lethal drugs to themselves, or must a physician administer them? If self-administration is allowed, should a physician be present? Should medical assistance in dying only be administered in health care settings? What about the home? The federal government recently tabled legislation that allows for both physician-administered and self-administration of the life-ending drugs, and also allows pharmacists to dispense directly to patients. The latter suggests medical assistance in dying could take place at home.

From the survey

Sixty-four per cent of survey respondents believed either the physician or the patient should be able to administer life-ending drugs, depending on what is agreed to by the two parties. However, 60 per cent believed a doctor or another health care professional should be present when the drugs are administered; 31 per cent believed there should be no requirement for a health professional to be present.

About 75 per cent of survey respondents considered all the locations presented – home, hospital, hospice, and assisted living or long-term care facility – to be appropriate locations to perform the procedure.

Administration of drugs

Submissions generally agreed that there is a need for flexibility as to who administers the drug and where the procedure takes place. However, they disagreed on whether a physician must be present. Some said the patient should have the autonomy to request the presence of someone other than a physician – a friend, family member, home care staff, or member of the clergy. Others said the physician should be present until death (even if not administering the drugs) to address the possibility of complications that could result in a prolonged death or a failure to die. In all cases, they said there is a need for processes that ensure lethal medications are not a risk to the community.

Challenges to access

Concerns were raised related to access in communities outside of large urban centres. It was noted that in many small and mid-sized communities, the only hospital is faith-based and this could limit access. Additionally, in smaller communities, it may be difficult to find two doctors willing to participate in an assessment (a safeguard recommended by the CPSA). It was suggested AHS and the CPSA work together to set up a system in which a patient could access an out-of-town physician. The physician could conduct the consultation either in person or by video conference.

Indigenous contributors told the MIA Consultation Panel that access to medical assistance in dying is even more problematic for their population, particularly for those living in remote First Nations communities. They noted that many of these communities do not have physicians or nurse practitioners, severely restricting their ability to die at home or even in their own community.

Conscientious objection

The Supreme Court recognized a physician's right to decline to provide medical assistance in dying based on moral or religious beliefs. However, if a physician declines, what obligation does the physician have to the patient? Should he or she be required to refer? Further, should any health care institutions have the right to refuse to perform this procedure?

From the survey

Approximately 55 per cent of survey respondents said physicians who do not want to provide medical assistance in dying should refer to a physician who does. A further 27 per cent said the physician should refer to a resource that would provide accurate information about all medical options. The remainder said the physician should not be required to provide a referral of any kind or did not have an opinion.

Approximately 44 per cent said all facilities, whether publicly funded or not, should be required to provide medical assistance in dying; 21 per cent said only publicly-funded facilities should be required to provide the service; and 27 per cent said no facility should be required to provide the service.

Conscientious objection of physicians and other health professionals

Almost every submission expressed an opinion on the right to conscientious objection. Most supported the right of physicians not to participate. The role of other professionals – especially nurses, pharmacists, psychologists and social workers – was also raised. Again, it was agreed that these professionals should have the right to refrain from participation. It was further suggested:

- All professionals involved have protection from criminal charges and civil liability.
- All related regulatory colleges align their standards of practice with the requirements of the Supreme Court decision.

On the matter of physician referral, opinions varied. Some felt that physicians with moral or religious objections should not be compelled to make direct referrals. Others said physicians, at a minimum, should be required to make a referral to another physician or a third-party.

- “Provincial legislation should not require, and should preclude the College of Physicians and Surgeons of Alberta from requiring, physicians to provide effective referrals for physician-assisted death. The requirement to provide a referral would clearly and unjustifiably interfere with freedom of conscience because it forces physicians to participate in an act to which they are conscientiously opposed.” – Submission from the Christian Legal Fellowship
- “While some Muslim doctors may not want to facilitate physician-assisted dying in any way, having the ability to refer such requests to another physician without participating in the procedure should be sufficient to reconcile the rights of physicians with the rights of patients.” – Submission from the Canadian Council of Imams
- “Physicians who oppose assisted dying for moral or religious reasons must be, at a minimum, required to transfer the care of the patient who requests it to another physician or

refer the patient to a third-party referral body, should one be in place.” – Submission from Dying With Dignity Canada

In stakeholder meetings, both the CPSA and the Alberta Medical Association recommended that, in the absence of a direct referral, physicians should refer patients to a formal source of information provided by AHS. Information could be available in a number of formats, including written, online, and by telephone.

There were a number of other recommendations to enable conscientious objection and referral:

- Government should institute an “opt in” or “opt out” provision and thoroughly train those who opt in.
- Alberta Health should keep a registry of physicians who will provide medical assistance in dying.
- Alberta Health should establish a “navigator” who could provide information and connect patients to participating health care providers.
- Physicians should refer patients to the executive director of the facility or the local health authority to arrange transfer of care.
- Government should appoint a provincial office to make referrals.

Conscientiously objecting health facilities

A few submissions said all publicly funded institutions should provide medical assistance in dying. However, the majority concluded that not every institution needs to provide the service. In particular, faith-based institutions should be exempted.

- “Physicians and faith-based care facilities should not be compelled to participate in physician-assisted dying if their conscience, faith or personal values do not allow for the taking of human life . . . Muslim health-care facilities will likely not want to facilitate or participate in physician-assisted dying in any way.” – Submission of the Canadian Council of Imams
- “Hospitals and other care facilities should not be required to perform such services and do so without penalties.” – Letter from Albertan

Covenant Health, Canada’s largest Catholic health care organization, has already said it will not participate in medical assistance in dying because it is not in keeping with the organization’s values or ethical guidelines. In cases where a patient wants to pursue this procedure, Covenant Health has indicated it will respond respectfully and compassionately, and explore other options including timely transfer of the patient to another health care institution.

- “We believe the province must consider the rights of caregivers and health care organizations whose conscience or religious conviction prevents them from being involved in physician-assisted death. We feel it is critical this legislation specifically protects and respects the freedoms of all Albertans.” – Submission from Covenant Health

Reporting and Monitoring

How should medical assistance in dying be monitored within the broader health system? How will we ensure it is done well? How will we know who is accessing the service and why? How will we evaluate and improve our policies and processes over time?

There were no survey questions related to this topic; however, many submissions commented on the need for a central reporting and monitoring system as an additional safeguard.

It was generally agreed that a record of every case of medical assistance in dying should be provided to a central registry office. It was suggested the central registry be housed within the Medical Examiner's Office, following a review to ensure it is adequately staffed and resourced to address these new manners of death. The *Fatalities Inquiries Act* could be amended to make it clear that investigation and autopsy by the medical examiner is not required in cases of medical assistance in dying except in unusual circumstances.

- “If medical examiners have jurisdiction and are able to track physician-assisted deaths and trends, it would provide protection for vulnerable people. In their decision, the Supreme Court of Canada decided that physician-assisted death could be provided as long as there is ‘scrupulous reporting’ of safeguards and the safeguards are strictly enforced. Scrupulous reporting requires medical examiner involvement.” – Juliet Guichon, assistant professor at Cumming School of Medicine, University of Calgary (from stakeholder meeting with the MLA Consultation Panel)

It was also suggested that:

- There should be a post hoc review of every case, and the system as a whole should be monitored to ensure it is functioning according to plan.
- There should be regular reporting of aggregate data to the public, for example, number of cases conducted yearly.
- Another body – possibly the Health Quality Council of Alberta – could collect data, and monitor and report on administration, complications, trends, and improvements.
- There should be a common way of describing the cause and manner of death, so meaningful data can be collected nationally.

The Office of the Information and Privacy Commissioner of Alberta cautioned that there needs to be clear authority for the collection, use and disclosure of personal information and health information required to provide medical assistance in dying. There is also a need to balance the right of access to the personal or health information of the deceased with protection of privacy of the deceased, including the use of information for health policy development or reporting purposes.

Palliative Care

Palliative care is a multidisciplinary approach that aims to improve the quality of life of patients and families facing life-limiting illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness. End-of-life care is provided closer to death, and may be more intensive in nature.

While questions about palliative care were not included in the survey, the subject came up repeatedly in submissions to the MLA Consultation Panel.

To ensure medical assistance in dying is not the only alternative to pain and suffering, submissions said the province must address current gaps and inconsistencies in palliative care. Any responsible policy on medical assistance in dying must guarantee access to quality, comprehensive palliative care for Albertans.

Many palliative practitioners expressed concern that the public may confuse palliative care and medical assistance in dying, pointing out that the goal of palliative care is to help the patient cope with physical and/or emotional or existential suffering, not to end the patient's life. As such, palliative care and medical assistance in dying are "philosophically and clinically distinct" and organizationally should remain as such.

A common concern was lack of equal access to palliative care, particularly in rural and remote areas and in First Nations communities. Indigenous contributors expressed concern about the lack of palliative and primary care services in their communities:

- "Going forward with this, if we are going to be dealing with end-of-life issues, there has to be funding for primary care networks to work with (First Nations) communities. A lot don't have primary care networks. In one large reserve there is no relationship with a primary care network despite thousands of members. Residents have to go in to the city to get that service. I believe there are a lot more people suffering in our communities than we are aware of." – AHS Wisdom Council member's comments at a meeting with the MLA Consultation Panel

It was suggested that all Albertans should have access to palliative care that meets national standards, and more emphasis should be placed on medical research focused on finding cures and improving pain management. In keeping with this sentiment, the Canadian Cancer Society called on provincial and territorial governments to recognize, through legislation, both the right of all Canadians to timely, high-quality palliative care, and the urgent need to improve access to such care, particularly for those approaching end of life. The Society recommends the development of national standards and performance indicators, and supports nationwide data collection and reporting and benchmarks for funding.

- "Without guaranteed access to these essential services right across the country, it will be impossible for Canadians to have full confidence in any government response to the specific issue of assisted dying." – Submission from the Canadian Cancer Society

Others also expressed strong support for palliative care:

- “Our prayer is that within this conversation we listen and respond to the real need for a truly universal and effective system of palliative, hospice and home care reinforced by excellent social services for the mentally and physically ill, elderly, disabled and those marginalized by other circumstances.” – Submission from the Catholic Bishops of Alberta
- “There is a need for enhanced paediatric-specific palliative care, funded and equipped to care for children and their families in the setting of their choosing, especially in their homes and home communities.” – Submission from the Canadian Paediatric Society

Other

Those who made submissions and participated in consultations raised a number of related issues that are briefly captured here.

Spiritual and ethical support

- Access to spiritual care needs to be embedded within any protocol or algorithm used by health care professionals in assessing eligibility for medical assistance in dying.
- There should be counselling support services available for the patient and their families/significant others, and all others involved.
- Along with educational resources, health care providers will need ethics resources, especially for consultation related to specific patient situations. Providing such resources and support for those working in rural and remote areas will be a challenge, but one that must be met.
- The Aboriginal Cultural Helper program within AHS should be expanded to help Indigenous people journey through the health care system and address end-of-life issues.
- A process is needed in Indigenous communities to deal with the residual effects of someone taking their own life. The family and community must be supported to ensure it doesn't negatively impact future generations.

"There needs to be a spiritual screening tool as part of the first conversation with a physician – something that asks about the meaning and purpose of life, beliefs, and whether they want to talk to someone further about these elements. This option should be revisited as the physician and client move forward."
– Submission from the Alberta Association for Spiritual Care

An Indigenous View

Physicians providing medical assistance in dying must be familiar with issues and beliefs important to Indigenous peoples. There is a need to partner with Indigenous organizations to ensure there is proper training in place for professionals involved in medical assistance in dying.

"We see life as a gift, and by choosing physician-assisted death or suicide, we are saying we don't honor this gift; that we want to end this gift. Our belief is that we will pay for this in the afterlife."
– AHS Wisdom Council member

"People are concerned that doctors now have tools to take their life or push them to end their life. This issue becomes bigger than physician-assisted death . . . How do we alleviate fear (of the health care system) if doctors now have a tool to help you end your own life."

– AHS Wisdom Council member

A pan-Canadian approach

- There is a need for a pan-Canadian approach that:
 - provides clear information to reduce confusion and misunderstanding
 - ensures consistent access to medical assistance in dying for all Canadians
- Federal, provincial and territorial governments should consider medical assistance in dying and end-of-life care as part of the development of a new multi-year Health Accord.
- A national oversight body should be created to promote a uniform standard of care and practice, and to ensure consistency of data monitoring and reporting.

The need for clear information and training

- Information must be readily available on websites, Health Link, and in places where patients receive care.
- All information should be written in language that is clear and understandable to a variety of audiences.
- In addition to having clear written information, Indigenous people seek information from their treaty chiefs, regional health groups, and communities; relationships with these groups should be nurtured.
- Health care providers also need a mechanism to access reliable information and resources for both themselves and their patients.

Insurance

- There needs to be clear understanding of the implications of medical assistance in dying in insurance and benefit packages, both for health care providers and users of the service.

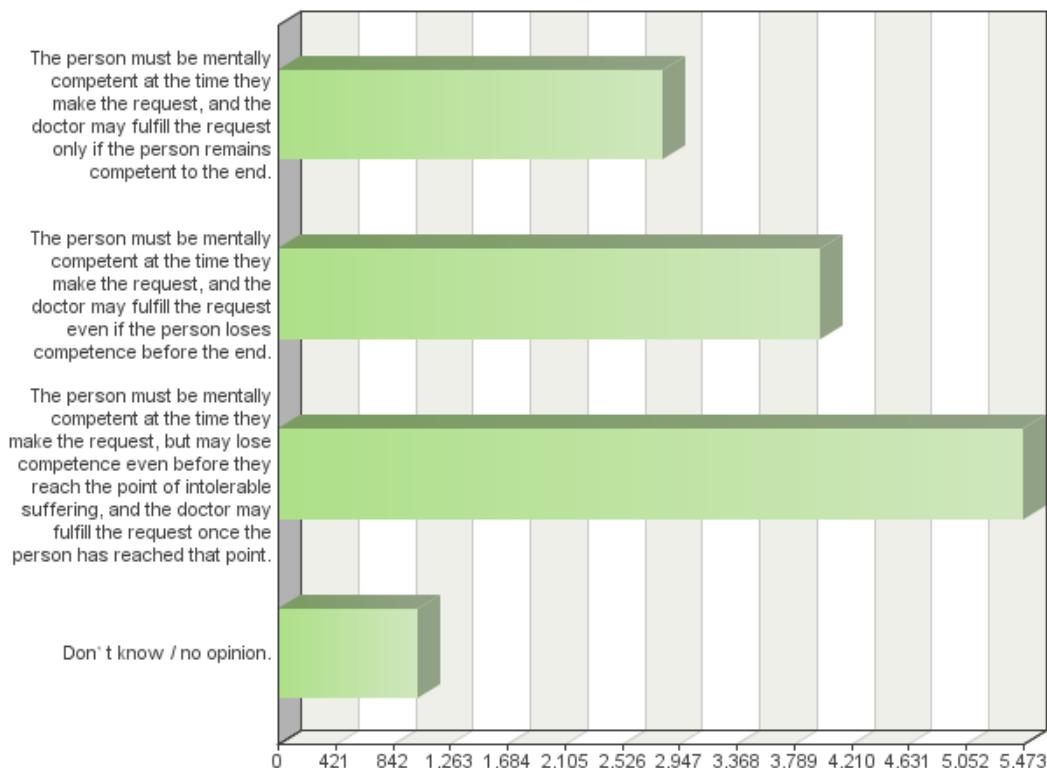
Next Steps

The views and input of Albertans will continue to be heard. The government will continue to consult as it moves forward, providing mechanisms for input and adjustment of its policies and processes.

Appendix: Survey Results

Question 1

The Supreme Court decision requires that any eligible patient must be competent. This means that the person has to understand what he/she is asking for when he/she requests the help of a doctor to die. But there are differing opinions about whether the person must remain mentally competent throughout the process. Which is closest to your opinion? Select one.

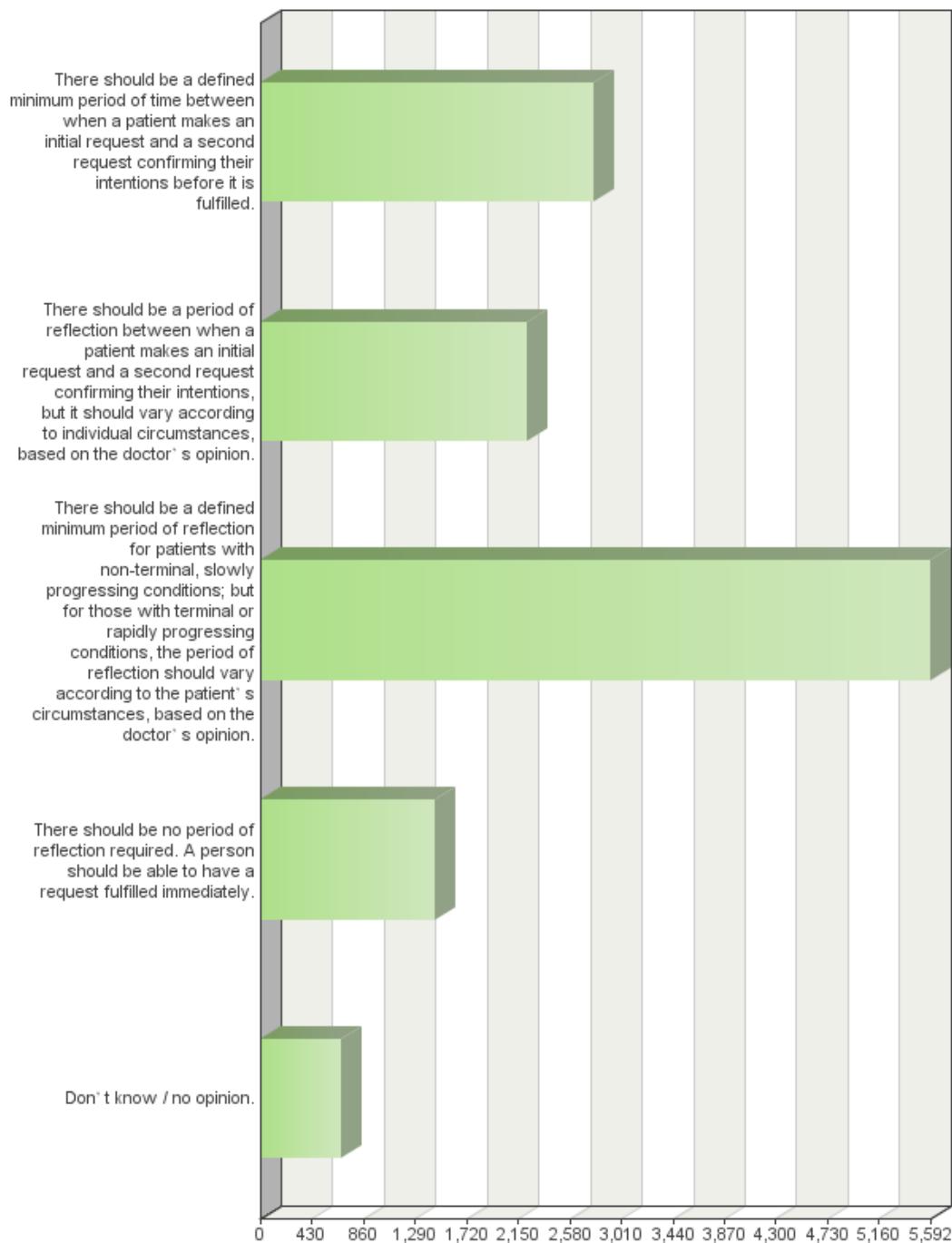


Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
The person must be mentally competent at the time they make the request, and the doctor may fulfill the request only if the person remains competent to the end.	2823	18.53%	21.21%
The person must be mentally competent at the time they make the request, and the doctor may fulfill the request even if the person loses competence before the end.	3984	26.16%	29.93%
The person must be mentally competent at the time they make the request, but may lose competence even before they reach the point of intolerable suffering, and the doctor may fulfill the request once the person has reached that point.	5473	35.93%	41.12%
Dont know / no opinion.	1031	6.77%	7.75%
Sum:	13311	87.39%	100%
Not answered:	1920	12.61%	-
Total answered: 13311			

Question 2

Some countries and states that already provide physician-assisted death require there to be a period of reflection for a person who requests it meaning a person is required to make a request for the procedure and a later second request confirming their intentions. Which is closest to your opinion?



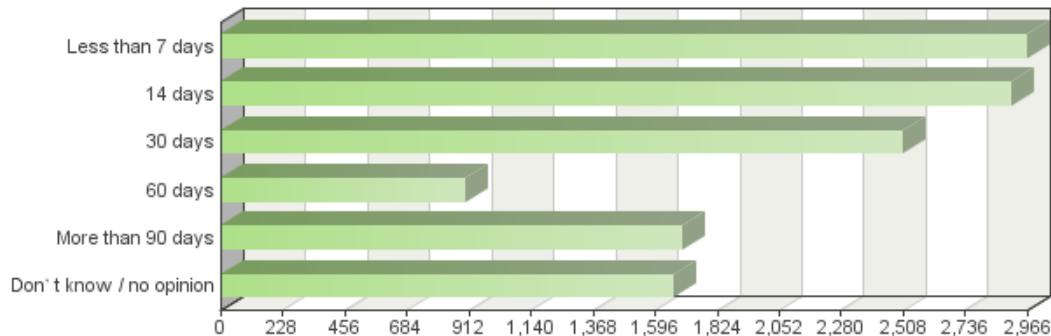
Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
There should be a defined minimum period of time between when a patient makes an initial request and a second request confirming their intentions before it is fulfilled.	2779	18.25%	21.82%
There should be a period of reflection between when a patient makes an initial request and a second request confirming their intentions, but it should vary according to individual circumstances, based on the doctors opinion.	2230	14.64%	17.51%
There should be a defined minimum period of reflection for patients with non-terminal, slowly progressing conditions; but for those with terminal or rapidly progressing conditions, the period of reflection should vary according to the patients circumstances, based on the doctors opinion.	5592	36.71%	43.91%
There should be no period of reflection required. A person should be able to have a request fulfilled immediately.	1460	9.59%	11.46%
Dont know / no opinion.	675	4.43%	5.3%
Sum:	12736	83.62%	100%
Not answered:	2495	16.38%	-

Total answered: 12736

Question 3

If there were to be a defined minimum period of reflection, what would the appropriate timeframe between the first and second request be?



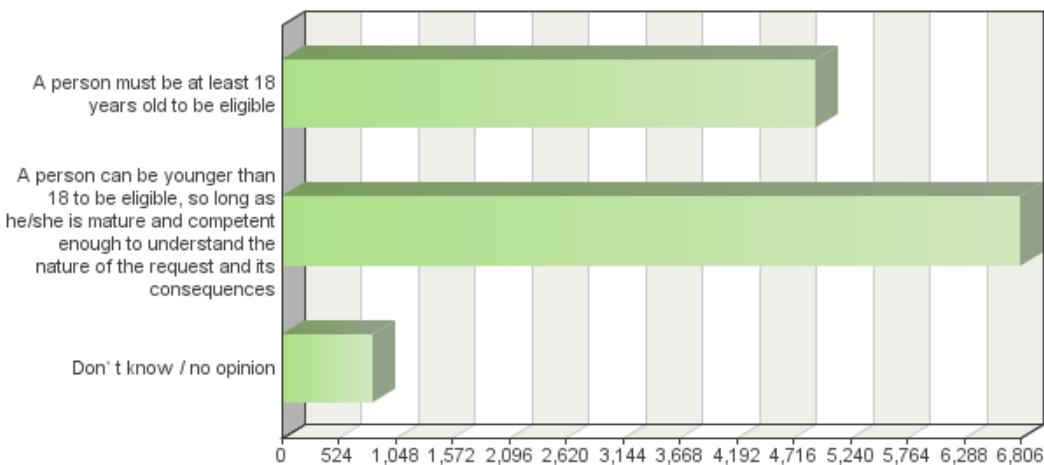
Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
Less than 7 days	2966	19.47%	23.44%
14 days	2911	19.11%	23.01%
30 days	2508	16.47%	19.82%
60 days	902	5.92%	7.13%
More than 90 days	1700	11.16%	13.44%
Dont know / no opinion	1664	10.93%	13.15%
Sum:	12651	83.06%	100%
Not answered:	2580	16.94%	-

Total answered: 12651

Question 4

The Supreme Court ruling applies to competent adults. Some believe people under age 18 should be eligible if they are mature enough to decide. In other words, age shouldn't matter; it's a question of competence and maturity. Which is closest to your opinion?

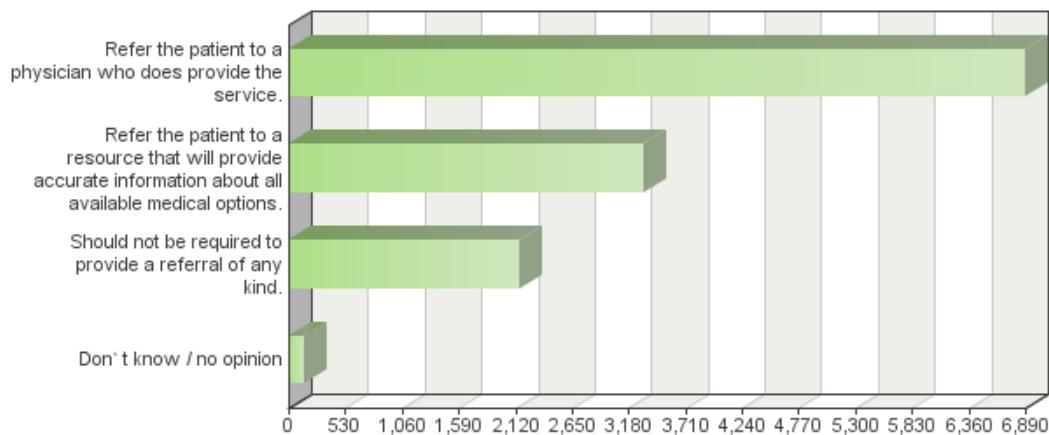


Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
A person must be at least 18 years old to be eligible	4927	32.35%	39.18%
A person can be younger than 18 to be eligible, so long as he/she is mature and competent enough to understand the nature of the request and its consequences	6806	44.69%	54.12%
Dont know / no opinion	842	5.53%	6.7%
Sum:	12575	82.56%	100%
Not answered:	2656	17.44%	-
Total answered: 12575			

Question 5

Doctors who do not wish to provide physician-assisted dying for religious or moral reasons will not be required to participate. If a patient of theirs makes a request of them, what should they be required to do?



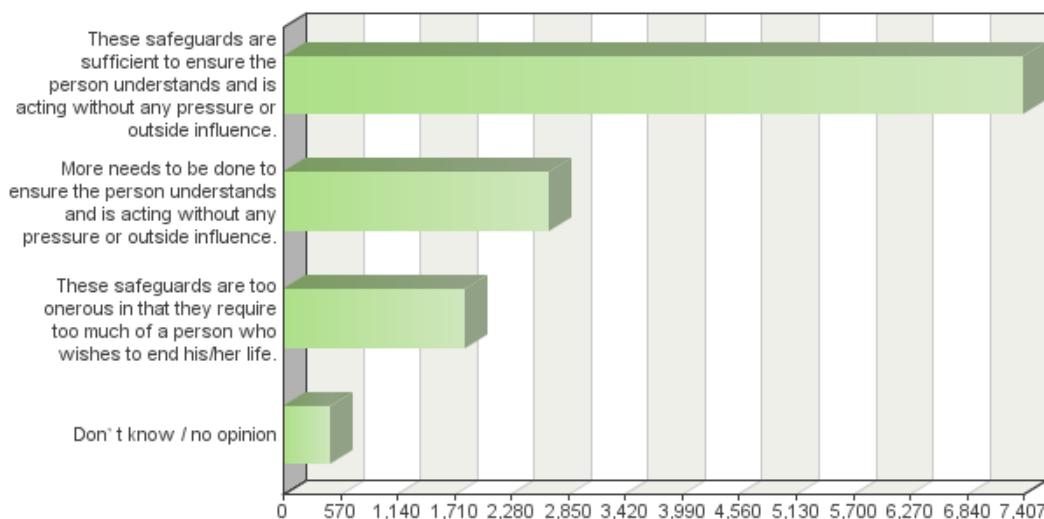
Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
Refer the patient to a physician who does provide the service.	6890	45.24%	55.01%
Refer the patient to a resource that will provide accurate information about all available medical options.	3328	21.85%	26.57%
Should not be required to provide a referral of any kind.	2158	14.17%	17.23%
Dont know / no opinion	148	0.97%	1.18%
Sum:	12524	82.23%	100%
Not answered:	2707	17.77%	-

Total answered: 12524

Question 6

The College of Physicians and Surgeons of Alberta has recommended several safeguards to help protect potentially vulnerable people, such as the elderly or disabled. These include the following: The patient must be made aware of all medical options; Two doctors must agree the person meets the criteria set out by the Supreme Court; If there is any question about the persons mental state, the person must be referred to a psychiatrist or psychologist; Two people must witness the persons request; and at least one of these witnesses must not be a relative or heir, or the owner, operator or employee of a health facility where the patient is receiving treatment, or the physician; The person must be advised at each step that he/she may change his/her mind, including just before the procedure is administered. Which is closest to your opinion?



Frequency table

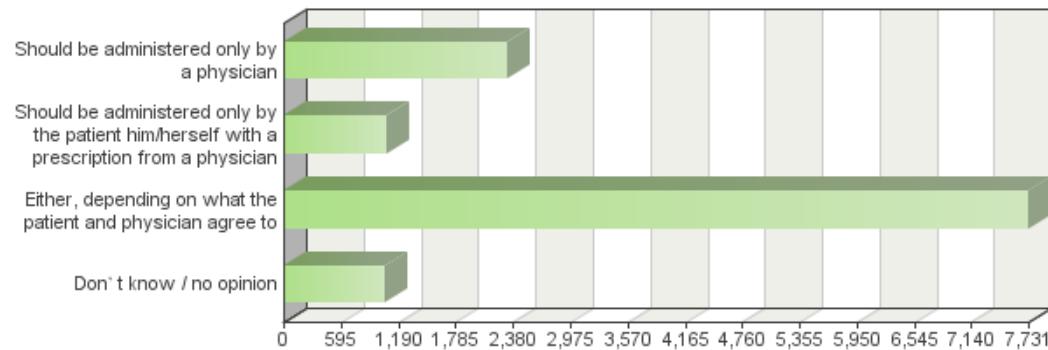
Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
These safeguards are sufficient to ensure the person understands and is acting without any pressure or outside influence.	7407	48.63%	59.87%
More needs to be done to ensure the person understands and is acting without any pressure or outside influence.	2663	17.48%	21.53%
These safeguards are too onerous in that they require too much of a person who wishes to end his/her life.	1824	11.98%	14.74%
Dont know / no opinion	477	3.13%	3.86%
Sum:	12371	81.22%	100%
Not answered:	2860	18.78%	-
Total answered: 12371			

Question 7

If you believe more needs to be done to ensure the person understands and is acting without any pressure or outside influence, what would you suggest?

Question 8

The drugs used in physician-assisted death:



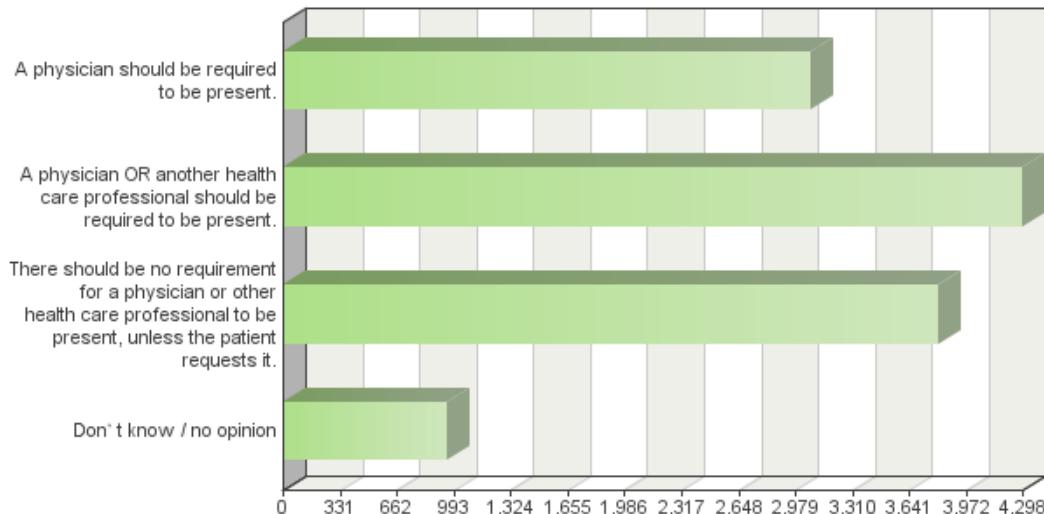
Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
Should be administered only by a physician	2318	15.22%	19.04%
Should be administered only by the patient him/herself with a prescription from a physician	1078	7.08%	8.85%
Either, depending on what the patient and physician agree to	7731	50.76%	63.49%
Dont know / no opinion	1050	6.89%	8.62%
Sum:	12177	79.95%	100%
Not answered:	3054	20.05%	-

Total answered: 12177

Question 9

If a patient is allowed to administer the drugs him/herself, should a physician or other health care professional be required to be present, in case there are complications?



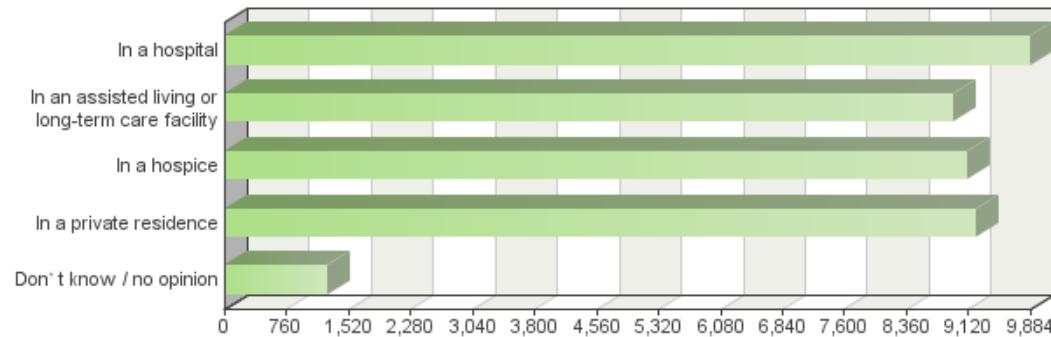
Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
A physician should be required to be present.	3071	20.16%	25.31%
A physician OR another health care professional should be required to be present.	4298	28.22%	35.42%
There should be no requirement for a physician or other health care professional to be present, unless the patient requests it.	3806	24.99%	31.37%
Dont know / no opinion	959	6.3%	7.9%
Sum:	12134	79.67%	100%
Not answered:	3097	20.33%	-

Total answered: 12134

Question 10

Which of the following locations should a patient's request be allowed to be fulfilled? (You may choose more than one)



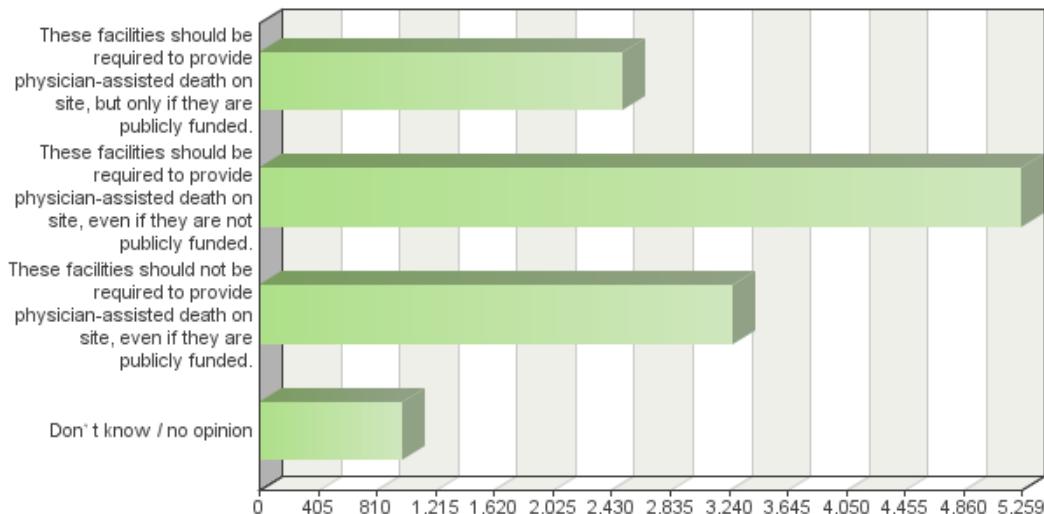
Frequency table

Choices	Absolute frequency	Relative frequency by choice	Relative frequency	Adjusted relative frequency
In a hospital	9884	25.73%	64.89%	81.65%
In an assisted living or long-term care facility	8939	23.27%	58.69%	73.85%
In a hospice	9106	23.71%	59.79%	75.23%
In a private residence	9211	23.98%	60.48%	76.09%
Dont know / no opinion	1271	3.31%	8.34%	10.5%
Sum:	38411	100%	-	-
Not answered:	3126	-	20.52%	-

Total answered: 12105

Question 11

Should hospitals, other health care facilities, long-term care and assisted living homes be allowed to deny access by patients to physician-assisted death? Which of the following is closest to our own opinion?



Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
These facilities should be required to provide physician-assisted death on site, but only if they are publicly funded.	2510	16.48%	20.86%
These facilities should be required to provide physician-assisted death on site, even if they are not publicly funded.	5259	34.53%	43.72%
These facilities should not be required to provide physician-assisted death on site, even if they are publicly funded.	3266	21.44%	27.15%
Dont know / no opinion	995	6.53%	8.27%
Sum:	12030	78.98%	100%
Not answered:	3201	21.02%	-

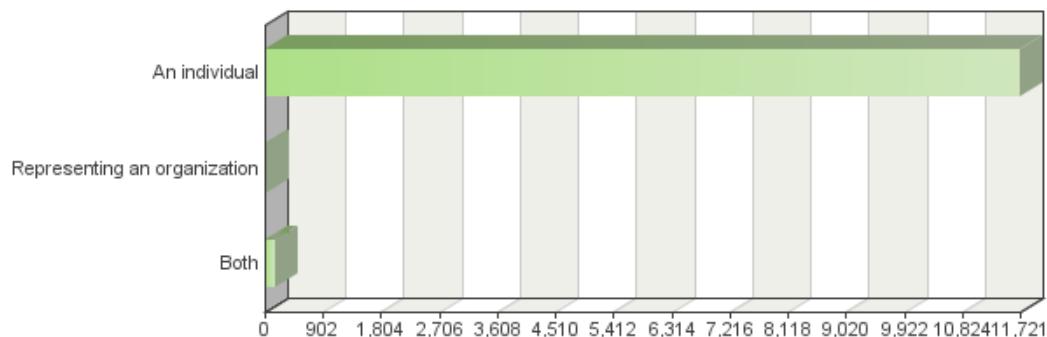
Total answered: 12030

Question 12

Please share any additional comments you have.

Question 13

Are you answering this survey as:



Frequency table

Choices	Absolute frequency	Relative frequency	Adjusted relative frequency
An individual	11721	76.95%	98.48%
Representing an organization	21	0.14%	0.18%
Both	160	1.05%	1.34%
Sum:	11902	78.14%	100%
Not answered:	3329	21.86%	-

Total answered: 11902

Appendix: Submissions

In addition to 31 letters and emails from Albertans, the MLA Consultation Panel received submissions from the following organizations:

- Advance Practice Nurses of the Palliative Care Consult Service in the Calgary Zone of Alberta Health Services
- Alberta College of Family Physicians
- Alberta College of Social Workers
- Alberta Health Advocates
- Alberta Hospice Palliative Care Association
- Brenda Stafford Foundation Ltd.
- Calgary Social Workers for Justice
- Canadian Association for Spiritual Care
- Canadian Bar Association – Alberta Branch
- Canadian Cancer Society
- Canadian Council of Imams
- Canadian Medical Protective Association
- Canadian Paediatric Society
- Catholic Bishops of Alberta
- Catholic Women's League of Canada
- Christian Legal Fellowship
- Coalition for Healthcare and Conscience
- College and Association of Registered Nurses of Alberta
- College of Alberta Psychologists
- Covenant Health
- Dying with Dignity Canada
- Health Quality Council of Alberta
- Inclusion Alberta (formerly Alberta Association for Community Living)
- Multiple Sclerosis Society of Canada
- Office of the Information and Privacy Commissioner of Alberta
- Premier's Council on the Status of Persons with Disabilities
- The Spiritual Assembly of the Baha'i's of Edmonton
- University of Alberta – Faculty of Medicine and Dentistry
- University of Alberta – Faculty of Nursing
- University of Alberta – Saint Joseph's College
- University of Calgary – Juliet Guichon et al., paper for Health Law in Canada, vol. 26, no. 3
- University of Calgary – Department of Philosophy