The Euthanasia Prevention Coalition (EPC) examined the 43 recommendations of the Provincial-Territorial Expert Advisory Group. The Euthanasia Prevention Coalition focuses on the following recommendations (see EPC's *concerns in red and Cambridge Right to Life's concerns in blue):*

Recommendation #3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

#3: The Advisory Group does not recognize a difference between euthanasia (physician-administered) and assisted suicide (self-administered).

Recommendation #4: Provinces and territories should require all regional health authorities to have an effective publicly funded care coordination system in place to ensure patient access to physician-assisted dying.

#4: The Advisory Group supports the creation of a death bureaucracy in every region of the country.

Recommendation #5: Provincial/territorial governments should publicly fund physician-assisted dying.

#5. The Advisory Group supports tax-payer funded assisted death. [CRTL Note: Since 60% of Ontarians already oppose paying $50M annually for abortion services, will there be a public outcry if they are forced to pay out more of their tax dollars for killing of the sick, disabled and elderly?]

Recommendation #8: Provinces and territories should request that the federal government amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

#8. The Advisory Group supports nurse participation in assisted death. Since the majority of doctors do not want to participate in euthanasia or assisted suicide, this recommendation is designed to expand the number of willing participants in acts of killing.

Recommendation # 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

#9. The Advisory Group doesn't want doctors or nurses to face lawsuits when a family member believes that a family member was inappropriately killed. This recommendation will enable abuses of the law to remain covered up.

Recommendation #13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.

#13. The Advisory Group is suggesting that the government should study the law to expand the law to people who made a prior request for euthanasia, such as through an advanced directive.

Recommendation #14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

#14. In the future, Recommendation 13 may supersede recommendation 14.

Recommendation #17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.

#17. The Advisory Group is suggesting that children with disabilities should have access to lethal injection.

Recommendation #18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

#18. The Advisory Group is suggesting that assisted death be limited to very severe conditions while offering no objective criteria to make this a reality. The Supreme Court decision was open to assisted death for psychological suffering, which cannot be defined or limited.

Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met.

#22. The Advisory Group is under the illusion that requiring two physicians to assess the patient will ensure that the criteria is met. **This "safeguard" does not negate a request when one of the physicians believes that the criteria are not met**, it only requires two physicians to agree.

Recommendation #26: We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.

#26. The Advisory Group does not recognize the importance of a waiting period as a time of reflection before lethally injection. Often, after a short time, a person will change their mind.

Recommendation #28: There should be no requirement that a physician be present at a self-administered assisted death.

#28. The Advisory Group is not requiring physicians be present during an assisted suicide death and yet recommendation 29 requires physicians to file a report concerning the death. When a person ingests a lethal dose, how will we know, for sure, that it was voluntary? This recommendation negates effective oversight.

Recommendation #29: Following the provision of physician assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

#29. **The Advisory Group is trusting that somehow an after-the-death reporting system, that requires the physician who causes the death, to self-report the assisted death, provides transparency and confirm compliance with existing policies and procedures**. Will doctors self-report abuse of the law?

The only way to ensure transparency and confirm compliance is by instituting a before-the-death reporting and court approval process.

Recommendation #30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician assisted dying should be listed as the cause of death.

#30. At least the Advisory Group recognizes the importance of accurate death certificates.

Recommendation #33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

#33. **The Advisory Group does not support physician's conscience rights.** Physicians who refuse to kill their patients should not be required to refer their patient to someone who will kill their patient.

Recommendation #38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

#38. **The Advisory Group does not support the rights of faith-based institutions.** The institution is not required to directly participate in killing patients, but it is required to arrange for their patients to be killed in another institution.

Recommendation #39: Provincial and territorial governments should establish a Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

#39. Recommendation 39 relates to recommendation 29. The establishment of a review committee is necessary, but the system of reporting will not ensure compliance with relevant legislation, regulatory standards, transparency or accountability. The data that the committee

reviews comes from the reports that are submitted by the physician who causes the death, after the patient is dead. **Physicians, like other human beings, will not self-report abuse of the law.**

Recommendation #42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.

#42. The Advisory Group is urging the continued training of doctors in the killing of their patients.

Recommendation 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices. [CRTL Note: We have been told that medical students are currently being trained on how to kill their patients in our Canadian Universities. How can this be if the practice is not yet legal?]

43. The Advisory Group is urging the education of the public in the efficacy of the law.