



Citizens With Disabilities – Ontario

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“Together We Are Stronger”

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Submission to the External Panel on Options for a Legislative Response to Carter v. Canada

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About Citizens with Disabilities – Ontario (CWDO)

CWDO is committed to the rights of all persons to participate fully in the civil, cultural, economic, political and social life of their communities.

We actively promote the rights, freedoms and responsibilities of persons with disabilities through community development, social action, and member support and referral.

Our primary activity is public education and awareness about the social and physical barriers that prevent the full inclusion of persons with disabilities in Ontario.

We have over 2000 members in almost every electoral district in Ontario and provide a newsletter to our subscribers to inform them of CWDO's activities and to report on relevant issues and developments.

About this Submission

CWDO is pleased to provide the federal External Panel with our submission outlining our thoughts on this sensitive and complex issue as well as our recommendations for the panel.

We are deeply concerned about this issue because of the potential for people with disabilities to be swept away in the carpet of physician-assisted suicide without having first had appropriate support to live and participate fully in the community.

In developing this submission, we have reached out to our members through a survey to better understand their views, to hear their worries about what this legislation might mean and to seek their advice on safeguards that would address their concerns. CWDO hosted a webinar in April and another in October to explore this issue in depth. This webinar was open to people all across Canada.

Individuals with disabilities have differing opinions about where to "draw the line" regarding when it should be legal to ask a physician for assistance to end one's own life. However, there is consensus among our members on other points.

This submission reflects the formal position and recommendations of CWDO, after considering the range of feedback received.

Bias

No one can come to a discussion about suicide or physician-assisted suicide without bias. It is therefore very important to disclose what that bias is for openness and transparency, and to take feedback in context.

We understand that the External Panel on Options for a Legislative Response to Carter v. Canada has been accused of bias against euthanasia and any form of physician-assisted suicide. We also understand that the Canadian Provincial/Territorial Provincial Panel Expert Advisory Group on Physician Assisted Suicide has a bias in favour of permitting physician-assisted suicide. The ultimate task will

be to weigh competing views in the balance and come up with something that is fair and just for all, including people with disabilities who may be vulnerable to coercion or persuasion to seek assistance to end their lives prematurely.

CWDO has a bias, too. We are biased in favour of the rights of persons with disabilities to live with dignity in the community. This includes the right to have adequate income support, medical care, home supports including attendant services, assistive devices and the range of supports that make full participation in the community, work, school and home possible.

We believe that all human beings have value and endless potential and that persons with disabilities have the right to live their lives without fear of being euthanized simply because they are persons with disabilities.

We believe that persons with disabilities deserve the same, full protection of the law and access to the justice system as any other citizen or resident of Canada.

We believe that killing people with disabilities simply because they are disabled is and should be treated as a hate crime and a crime against humanity. Individuals convicted of such crimes should receive the maximum sentence allowed for by Canadian law, with no exceptions.

We hope everyone who responds to your call for written submissions declares their biases openly and honestly as well.

Terminology

Suicide

The Miriam-Webster dictionary defines the term "suicide" as "the act of killing yourself because you do not want to continue living; a person who commits suicide."

The actor in the act of suicide is the person him or herself. It is not something done to them, but rather something the person chooses to do for themselves.

Physician-assisted suicide

Physician-assisted suicide is when a doctor gives another person a means to end their life. Again, the actor is really the person, and the doctor is the enabler.

Because the Supreme Court found that it was discriminatory to refuse assistance to a person who wanted to kill themselves, but could not do it unaided, they struck down the law that made it illegal to help someone do this. CWDO would call this "physician-assisted suicide."

Physician-assisted death/dying

Disturbingly, the discourse on this topic has changed over the past few months. What was originally referred to as physician-assisted suicide, is now more broadly referred to as physician-assisted dying or physician-assisted death.

Euthanasia

Euthanasia is when another person commits the act that ends someone's life. With euthanasia, the individual may or may not have a say about it. The cases that reach the media are often those where people do not have a say – such as Tracy Latimer.

CWDO is concerned that the use of the broader terms physician-assisted dying or physician-assisted death will be interpreted to encompass other methods of "helping" people to die, such as euthanasia. Euthanasia imposes the view of one person on another that their life is not worth living, or that they would be better off dead.

For clarity, CWDO will be using the term physician-assisted suicide in this submission to reinforce that our comments focus on people who actively make this choice for themselves.

About the External Panel on Options for a Legislative Response to *Carter v. Canada*

On February 6, 2015, the Supreme Court of Canada declared that the current prohibition on assisted dying violates the Charter rights of certain people with serious medical conditions who want a doctor's assistance to die. This case is now known as *Carter vs. Canada*, or the *Carter* decision.

As part of its response to the *Carter* decision, the government of Canada established the External Panel on Options for a Legislative Response to *Carter v. Canada* to engage Canadians and key stakeholders on important issues relating to physician-assisted dying, such as identifying the risks and considering what rules and safeguards could look like.

CWDO understands from the government website that the mandate of the External Panel is to engage Canadians and key stakeholders on issues the federal government will need to consider in its response to the *Carter* ruling. The Panel is required to submit a final report to the federal Ministers of Justice and Health that will outline key findings and options for consideration by the Ministers.

We understand that the External Panel is not responsible for making decisions on this issue. Its task is to gather input and give balanced, thoughtful attention to the range of options for the federal government to consider. Parliament may then use this information to create new federal laws to guide physician-assisted dying in Canada. The provinces', territories' and physicians' colleges will also have a role in shaping how assisted dying is regulated in their areas.

We understand that the Supreme Court has made its decision.

While CWDO has serious concerns about the Court's decision because of the potential risks it poses to people with disabilities, we are seriously undertaking to propose safeguards to mitigate some of the risks resulting from their decision.

Background

People with disabilities have historically been objects of pity/charity, ridiculed, rendered as subhuman organisms, feared, despised, shunned, persecuted and banished from the mainstream of society.

Despite efforts in the late 20th century to the present day to promote the equality of people with disabilities, raise awareness and protect our rights, vestiges of these historical attitudes remain.

People with disabilities have higher rates of unemployment; higher rates of institutionalization; lower rates of education; less likelihood of being married or having children.

As a society, Canada has greatly improved health outcomes which means fewer infants die due to illness and disability and the life expectancy of people in our country and province has been almost doubled in the past 60 years. While lives are saved, more people are living with disabilities: babies are surviving with more severe disabilities than might have been possible decades ago; and people are surviving with disabilities which might have ended their lives in earlier times.

The *Globe & Mail* reported on September 29, 2015 that for the first time in its history, [Canada has more seniors than we have children](#).

In a 2004 report, [The Lifetime Distribution of Health Care Costs](#), the US National Library of Medicine's National Institutes of Health reports the distribution of health care costs is strongly age dependent, a phenomenon that takes on increasing relevance as the baby boom generation ages. After the first year of life, health care costs are lowest for children, rise slowly throughout adult life, and increase exponentially after age 50 ([Meerding et al. 1998](#)). [Bradford and Max \(1996\)](#) determined that annual costs for the elderly are approximately four to five times those of people in their early teens. Personal health expenditure also rises sharply with age within the Medicare population. The oldest group (85+) consumes three times as much health care per person as those 65–74, and twice as much as those 75–84 ([Fuchs 1998](#)). Nursing home and short-stay hospital use also increases with age, especially for older adults ([Liang et al. 1996](#)).

The same would be true in Canada. The cost of care for a senior is three times higher than for the average person ([Ontario's Action Plan for Health Care](#): 2012). Frequent media attention on this issue also points out that people will use 80% of all the health care services they will use in their lifetime in the last 10% of their life.

As the number of people with disabilities grows, the demand for community-based services like home care, nursing care and accessible transportation inflates. Governments at all levels struggle with deficits and high interest rates. 42% of our tax dollars are devoted to health care, and health care costs have been increasing year after year. It is estimated that health care will reach 70% by 2032 (Ontario's Action Plan). All health sectors are already struggling to meet the demand as more and more people are eligible for their services.

It is well-known that incidence of disability increases with age. Therefore, it is not surprising to CWDO that there would be unrelenting pressure on the courts until physician-assisted suicide and even euthanasia would become increasingly permissible. While arguments in support are positioned as human rights issues, the cost-benefit analysis is undoubtedly the underlying motive for society's overall support for physician-assisted suicide:

- If people die sooner, before health issues emerge, there will be savings to health care costs.
- If people die sooner, demand for community-based services like home care, nursing care, and accessible transportation will decrease, or increase more slowly.

Add to this mix that our culture views any loss of ability to be abhorrent. People fear disability. Our culture views it irresponsible to cause or permit disabilities to manifest themselves.

No matter how much society takes steps to "level the playing field" for people with disabilities, society is conflicted: While great strides have been made in integration and acceptance of people with disabilities, having a disability is still not an enviable state. When was the last time you heard someone say happily, "Oh how wonderful! Your baby has a disability!" or "Congratulations! You broke your back and are

now permanently disabled. I'm thrilled for you!" No matter how much people may say they accept people with disabilities, our disabilities are not accepted. When our disabilities are not accepted (and they are, for many of us, inseparable from our identity), people with disabilities are rejected on some level, just as their disability is rejected.

These pervasive attitudes make persons with disabilities extremely vulnerable when decisions are made about where to devote resources and even decisions about who may live and who may die.

Although the Supreme Court found it discriminatory to forbid assistance to someone who wishes to kill themselves, CWDO is concerned that physician-assisted suicide will also prove to be discriminatory: non-disabled people who express suicidal wishes will be offered suicide prevention programs and be surrounded by people who wish to demonstrate that life is worth living; while people with disabilities will receive all the assistance they need to help them and their own life.

This old cartoon (c. 1980, artist unknown) wryly expresses the view that people with disabilities will literally be "steered" to decide to end their own lives.



Society devalues life with a disability. People who are not disabled will often express a sentiment, if asked, that they would rather be dead than have a disability. They believe that suicide is a rational response to severe disability.

CWDO does not agree that suicide is a rational response. Time and time again, we hear from people who, although they may have expressed a wish to die when they first became disabled, a year or two later they have found that not only does life go on, but it can be very good. They find they do not have to give up their old loves and lifestyles, but can adapt them to their new reality.

Is Suicide Ever a Real Choice?

People may support physician-assisted suicide if they believe it is the person's choice. CWDO supports the view of Not Dead Yet/*Toujours vivant*, that there can be no free, real or actual choice to die as long as people with disabilities have no choice in where and how they live.

People with disabilities are chronically under-supported in our society with regard to educational, income, community, home care and medical supports. High quality palliative care is not readily available in all parts of our province when needed; only 32% of our members who responded to our survey indicated that high quality palliative care would be available to them should they need it.

Without these basic supports, people with disabilities are prevented from experiencing quality of life. If people with disabilities choose physician-assisted suicide due to a lack of supports, it should be a source of deep shame for our country. Is the "choice" to kill oneself being made because of the disability and a perception that it will lead to loss of autonomy, independence and dignity; or because people with disabilities are not valued enough to ensure that the necessary supports to provide a quality of life are readily and consistently available?

Our Members' Fears

People with disabilities are vulnerable for many reasons. Because of societal attitudes outlined above, often they may have very small social circles, lower education and therefore more difficulty accessing information and getting meaningful employment and adequate income. People with disabilities are not treated as well in the health care

system – examination rooms, medical equipment and treatments have been designed for people who are otherwise mobile and fully functional. It is well documented that people with disabilities delay preventative treatment or are discouraged from having preventative tests or treatment because of the logistical difficulties inherent in having inaccessible equipment and exam rooms.

People with disabilities are vulnerable because those in the medical profession tend to avoid specializing in less exciting "chronic" conditions, preferring the excitement of transplants and rehabilitation medicine where progress and improvement can be graphed and sometimes quite dramatically displayed. Many physicians feel deflated when there is nothing more that can be done to reverse a disability or illness. This sense of failure that some physicians feel when confronted with a disability that will not go away, even with treatment, is interwoven with a sense that disability is a negative state, and one to be avoided. People who live with disabilities must sometimes deal with doctors who feel guilty that there is nothing more that can be done, and who live and breathe "ableism" as a defining goal of their profession.

People with disabilities may be induced to commit suicide in any number of overt and subtle ways. For example, denial of services and inadequate funding to ensure services are available may steer someone with a disability toward a decision to have help to kill themselves. What incentives will there be to improve community services, nursing homes and medical facilities when people can simply be offered a "treatment option" to have help to end their life?

People with disabilities may be induced to commit suicide if they feel they have become a burden to others (also related to the (un)availability of community supports). People with disabilities may feel they are doing others a favour, by choosing to end it all. People with disabilities may feel that they will be honoured by loved ones for sparing them and ending their life.

People with disabilities are also concerned that there may be circumstances in which they would want to have the right to have assistance to end their life in specific and extreme circumstances. They would not want to be forced to suffer pain if the end was near.

Here are some statements from our members outlining their fears:

- 71% worry that there will be less public support and/or fewer resources for accommodating persons with disabilities, mental health conditions or chronic health conditions.
- 71% worry that the medical profession will be quick to place a "do not resuscitate" order on them, especially if they cannot speak for themselves.
- 68% worry that having the right to request assistance to die will reinforce public perception that having a disability makes life not worth living.
- 65% worry that one day people will encourage them to ask to die instead of providing high quality services to live in the community.
- 59% worry that they or a loved one will request assistance to die because they will not have the time or financial resources to care for themselves or another family member at home at the end of their lives.
- 56% worry that they will be encouraged to request assistance to die so that they would not be a burden to their family or the health care system.
- 53% worry that our society will increasingly become a society that wants to eradicate disability by getting rid of people with disabilities at every opportunity.
- Some members expressed their concerns in the following verbatim comments:
 - "insurance companies having any input whatsoever since they are looking after their best interests as opposed to the public interest"
 - "I worry that I may consent to something while I am under the influence of heavy medication, or depressed or that I

don't understand what I signed if English is not my first language”

- “My real concern, and it is a little personal because I experienced it myself a little; if a person like myself with a speech impairment goes to a new doctor and takes someone with them to help interpret, the doctor tends to speak to the person who’s doing the interpretation rather than the patient. Now, granted, I should take someone who won’t take over the conversation and would direct the doctor to speak to me, but not everyone picks who gets to go with them. This scenario might be a little off but it is a concern of mine.”

CWDO’s Recommended Safeguards

CWDO consulted with its members through a survey and two webinars and has reflected on submissions from a number of organizations run by people with disabilities.

In the Benelux Countries (Belgium, Netherlands, Luxembourg), the number of deaths by assisted suicide/euthanasia is increasing exponentially. According to data cited by the trial judge (para. 475 and 578) updated by the Netherlands Annual and Belgium Biannual Reports, and dropping out the first [incomplete year] the number of deaths has increased 64.13% annually in the Netherlands and 47.77% in Belgium.

Once this new law is enacted, CWDO has every reason to expect that there will be numerous requests to broaden the mandate beyond physician-assisted suicide, resulting in broader criteria and seeing more and more adults – and children and infants – be granted a premature death.

Are there any safeguards that can be put in place that can 100% guarantee there will not be an increasing and disproportionate number of people with disabilities and seniors having their lives ended before their time? Perhaps not.

Nevertheless, CWDO offers the following suggestions for safeguards to be considered in the legislative options in the hope that even if it cannot 100% guarantee abuses of the new law, it will help.

1. Take clear and definite steps to promote and implement in a meaningful way the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

The United Nations Convention on the Rights of Persons with Disabilities (CRPD), articulates how States Parties to the CRPD shall ensure that people with disabilities experience full enjoyment of human rights.

The CRPD's Article 10 states that: "Right to Life—States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure the effective enjoyment by persons with disabilities on an equal basis with others."

Article 14 obliges States Parties to ensure disabled people's enjoyment of the right to liberty and security of the person.

Article 25 on Health states that "...States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services... In particular, States Parties shall: ... (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability."

Given the Supreme Court's decision in *Carter vs. Canada*, there will be some situations in which physician-assisted suicide will be legal. There is a danger that under the new law, Canada and its provinces/territories could undercut the intent of the CRPD. Safeguards, therefore, need to be built into the new law to protect people with disabilities to maintain their human right to live, to enjoy that life and to have access to health care/services and food/fluids. These rights must not be undercut by the new legislation.

2. Promote public education to reduce (and ultimately eradicate) the stereotype that life with a disability is not worth living, and that people with disabilities are unable to make contributions or enjoy a quality of life.

CWDO supports the Council of Canadians with Disabilities' (CCD) view, as presented by representatives from their Ending of Life Ethics Committee's June 16, 2010 Submission to Parliamentary Committee on Palliative and Compassionate Care in Ottawa:

"Negative attitudes about disability, combined with poverty and social isolation, increase the vulnerability of people with disabilities, who are seriously ill or dying, to experiencing discrimination and death hastening responses in the medical system. The negative and ableist assumptions in question include the ideas that— people with disabilities have no "quality of life", that lives with disability are not worth preserving, that lives with disability are a burden."

3. Restrict access to physician-assisted suicide to people who can actively make the request themselves.

Assistance to die would be made available where a person is able to request it themselves, and never "on behalf" of a person who is not able to communicate their wishes.

This may be accomplished through a direct request, an advanced health care directive, or by means of augmentative communication for people who are competent and conscious, but not able to speak verbally.

With respect to an advanced health care directive, a person's wishes need to be reviewed just prior to carrying out the instructions, to ensure that an individual has not had a change of heart.

It is very common for people who acquire disabilities partway through their lives to go through a period of shock, depression, grieving and adjustment. However, their wishes may change if given the opportunity to experience the adjustment stage.

4. Restrict access to physician-assisted suicide only to people who are terminally ill, and whose death is imminent.

CWDO believes that access should be restricted to those who are terminally ill and whose death is imminent. Physician-assisted suicide

would not be permitted for people who have disabilities unless they were also terminally ill and their death was imminent.

“Imminent” would mean that death was likely within a few months. Physician-assisted suicide would NOT be made available for people who have disabilities such as spina bifida, cerebral palsy, down syndrome, schizophrenia, muscular dystrophy, clinical depression, etc. unless there was another condition such as cancer, making their death imminent.

5. Make it a criminal offence to coerce or unduly influence any person to commit suicide or request physician-assisted suicide.

This recommendation is intended to reduce the number of situations where families might "encourage" someone to take this option where they have something to gain (e.g., an inheritance). It should also cover situations where insurance companies attempt to change their policies to a) refuse to pay a death benefit to someone who is terminally ill, whose death was imminent, but who chose to hasten their death through physician-assisted suicide; or b) enticing a policyholder to request physician-assisted suicide in order to reduce insurance companies' costs.

This safeguard should include situations where anyone has made another person's existence so untenable that they believe suicide is their only option. For example:

- Failing to withhold the necessities of life
- Unduly limiting someone's access to community services and supports
- Failing to provide adequate services at home, group homes, institutions or other facilities to enable people to enjoy life and make life worth living
- bullying, belittling, and other forms of psychological abuse

6. Physician-assisted suicide would only be made available after a detailed and individualized plan for high-quality, palliative care has been thoroughly presented, considered

and refused, including medical therapy to relieve pain and suffering.

This safeguard requires that there actually be choices and will be a good reason to ensure that suicide prevention counseling and high quality palliative care is available in every community. According to our member survey, fewer than 30% of our members across Ontario currently have access to high quality, palliative care.

7. Physician-assisted suicide would only be permitted if people had sought out and received ongoing suicide-prevention counseling, such as would be provided to non-disabled persons.

8. Physician-assisted suicide would only be permitted if the patient had undergone an assessment of competence, including a reasonable length of time to adapt to new circumstances such as those brought on by a traumatic injury.

The above safeguards are critical to help ensure that people with disabilities will not be discriminated against by being "steered" toward a "choice" to have physician-assisted suicide.

Together, these safeguards ensure that people making the request are of sound mind, and that their circumstances are not temporary nor based on episodic or cyclical mental illness. These safeguards also ensure that people requesting physician-assisted suicide will have a reasonable amount of time to adjust to their circumstances. To the average person, having a disability may seem frightening and catastrophic. However, as one adapts to living with a disability, reality sets in – a new, OK reality – the desire to end one's life dissipates over time.

9. The legislation would require each province and territory to ensure the availability of high-quality palliative care, home care, transportation, psychological services, assistive devices and attendant services to support people with disabilities and seniors to live at home and participate in the community.

Without this infrastructure in place, any law that would be created at the federal level would be a death sentence for people with disabilities who would find they have no real alternative than requesting assisted suicide, due to a lack of community supports.

10. The legislation would provide for an appeal mechanism.

Appeal mechanisms will be important, especially as the law is initially implemented.

- People with disabilities may wish to appeal the decision of their physician to refuse to assist them to commit suicide.
- Family members may wish to appeal the decision to assist someone to commit suicide.
- Physicians may wish to appeal decisions impacting on their role in providing or not providing assistance to commit suicide.

CWDO recommends that each province establish an appeal board. This appeal board would comprise representation of medical, psychological and community service expertise, and someone living successfully with a permanent disability. All members of the appeal board would receive remuneration for their participation. Ironically, the cost of this appeal body may be offset by the savings incurred as a result of physician-assisted suicide requests that are granted, and their subsequent reduction in need for health care costs.

11. Accountability measures will be part of the legislative regime, including annual public reports.

Annual reports should be at the provincial level and include the following information in ways which do not identify any patients:

- Reasons for the requests
- Primary medical condition (for example, cancer)
- Number of requests granted
- Number of requests denied
- Names of doctors granting requests and number of people each doctor assisted to commit suicide

- Service options available in the community (for example, palliative care at home, palliative care in hospital) including any wait times to receive those services, if applicable
- The method used to grant the request (for example, lethal oral medication, lethal intravenous injection, etc.).

Accountability for this new law will be crucial to assess outcomes; assure the public that request granted are clearly aligned with the permissions granted by the new law; and that the new law is not being abused.

We feel it is important to name the doctors granting requests in order to determine if there are doctors who appear too eager to assist patients to commit suicide. We would expect to see a very small number of requests being granted, but accountability will disclose the rate of growth in this new death-industry.

Reporting on other services available will provide important data on the extent to which other options are available which provide people with a "true choice." We would expect to see over time, more community options for people who are at the end of their life.

Reporting at the provincial level will allow for aggregate numbers which would protect a patient's identity yet allow province to province comparisons. Provincial level reporting will enable the public to be aware of which provinces are more inclined to assist people to end their lives rather than have services in place.

Physician-assisted suicide legislation should be reviewed regularly.

CWDO recommends that the new physician-assisted suicide legislation be reviewed by a federal panel every five years, informed by the results of the provincial/territorial reports. This will identify how the law is being implemented and if it is being implemented as intended.

The review panel should comprise people with medical, psychological and community service expertise, and representatives of organizations led by persons with disabilities such as the Council of Canadians with

Disabilities. All members of the federal review panel would receive remuneration for their work.

The federal review panel would be empowered to make recommendations to amend the law governing physician-assisted suicide as well as make amendments to any other relevant laws.

Draft Legislation

On October 4, at CWDO's webinar, "Facing a Future with Assisted Suicide," David Baker (Bakerlaw) and Gilbert Sharpe, presented draft legislation that addresses the *Carter* decision. CWDO believes this legislation should be given serious consideration by the panel in making its recommendations to the Ministers of Justice and Health.

The [Bakerlaw legislation](#) addresses a number of key aspects that would need to be included in any legislation permitting physician-assisted suicide:

- Initiating a written request and form of the written request
- Responsible physician responsibilities, assisting physician responsibilities and consulting physician confirmation
- Counseling referral
- Next of kin notification
- Role of the public guardian and trustee
- Medical record documentation requirements for the application
- Application to a review board and orders from the review board
- Informed decision and right to rescind request
- Insurance or annuity policies
- Billing – physicians
- Offenses and penalties
- Definitions

CWDO supports Bakerlaw's draft definition of vulnerability:

“Vulnerable” means a patient making a request who, in the opinion of the patient's responsible or consulting physician, may be experiencing some or all of the following, any one of which could induce a person to commit suicide:

- a) Lack of access to medically necessary treatment including proportionate palliative care;
- b) Lack of access to alternative services necessary for the patient to lead an independent, dignified and comfortable life;
- c) Lack of the opportunity to come to terms with the patient's prognosis;
- d) Lack of awareness of how persons with an illness or condition comparable to that of the patient have nevertheless come to live meaningful and dignified lives;
- e) Social isolation, loss of independence, poverty, fear of becoming a burden on others, or a self-image weakened by anticipated exclusion, disadvantage or discrimination; or
- f) Diminished competency due to a psychiatric or psychological disorder or depression capable of causing impaired judgment

CWDO believes this draft legislation is a strong start to writing a new law which will protect people with disabilities from being "steered" toward a "choice" of physician-assisted suicide due to a lack of other supports and/or misinformation about the choices available.

Its many elements create a number of safeguards against inducements of vulnerable people, as listed above.

Conclusion

CWDO would have preferred that the law making physician-assisted suicide illegal was unchanged. Given the decision of the Supreme Court in *Carter vs. Canada*, it is clear the law has been struck down, a new law will be created and the law will continue to evolve.

Our concern is to ensure that people with disabilities are not jeopardized as a result of this new law. We want to ensure that people

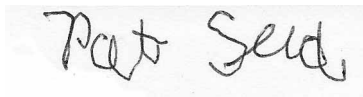
who are ill and suffering with terminal illnesses, when their death is imminent, have options about their end-of-life choices. At the same time, we want to ensure that people with disabilities have real choices to make – choices based on a strong array of care options, including high-quality palliative care.

Efforts have already been made to draft legislation that to us is a good start in allowing rights, yet protecting rights.

It will take a strong and clear piece of legislation to ensure that this new law will not abduct people with disabilities and carry us unwillingly to places we do not want to go.

Should you have any questions or desire clarification about anything in the submission, please contact me.

Thank you for the opportunity to provide input.

A handwritten signature in black ink that reads "Pat Seed". The signature is written in a cursive, slightly slanted style.

Pat Seed, Chairperson
Citizens With Disabilities – Ontario

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