EFC

The Evangelical Fellowship of Canada

Submission to the Senate Standing Committee on Legal and Constitutional Affairs

Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*

May 9, 2016

Introduction

The Evangelical Fellowship of Canada is the national association of evangelical Christians, with affiliates including 42 denominations, 65 ministry organizations, 38 post-secondary institutions and more than 700 individual congregations. Formed in 1964, the EFC provides a national forum for Canada's four million Evangelicals and a constructive voice for biblical principles in life and society.

Many of our affiliates provide end-of-life care in seniors residences and long-term care facilities, as well as hospice care. We have affiliates who provide assistance and care for Canadians with disabilities. Many evangelicals are medical professionals. Within congregations, ministers provide pastoral care to those who are in crisis, who are elderly, who are at the end of life.

The EFC has been involved in discussions on euthanasia and assisted suicide for decades, acting as an intervener before the Supreme Court in *Carter v. Canada*, and in *Rodriguez v. British Columbia.* We made submissions to the Special Joint Committee and the Justice Committee earlier this year, the federal and provincial-territorial panels in the fall, and to various Parliamentary committees on these issues since the 1990s.

In fall of 2015, the EFC and the Canadian Conference of Catholic Bishops released a joint statement on euthanasia and assisted suicide that has been endorsed by more than 25,000 signatories to date, including evangelical, Catholic and Orthodox leaders, and more than 20 Jewish and Muslim leaders from across Canada.[1]

We believe the proper response to suffering, and particularly to those who are nearing the end of life, is to respond with care and compassion, and to journey with those who are walking in the shadow of death.

On the basis of our beliefs and commitment to the sanctity of human life, we are unequivocally opposed to both assisted suicide and euthanasia. Since the government is proceeding with enabling legislation, our recommended amendments are intended to minimize the harm and risk to vulnerable Canadians, to protect freedom of conscience and religion for medical practitioners and institutions that provide end of life care, and to protect our society's commitment to respect for life.

Principles

In this submission, we advocate for respect for life and care for the vulnerable. We affirm these two principles from out of our faith tradition. These principles have shaped Canadian law historically, and were recognized by the Supreme Court in the *Carter* decision.

[1] Declaration on Euthanasia and Assisted Suicide (www.euthanasiadeclaration.ca).

The sanctity of human life, or respect for life, is broadly recognized by all Canadians and is a foundational principle of Canadian society.[2] It undergirds the recognition of the equal dignity of each individual regardless of their abilities or disabilities. It shapes and guides our common life together, including our legal, health care and social welfare systems. The sanctity of human life also engenders the collective promotion of life and the protection of the vulnerable.[3]

Canada has a long legal history of unambiguously affirming the sanctity of human life. Parliament itself has said no to euthanasia and assisted suicide repeatedly, most recently in 2010. This was in no way because Parliament was unconcerned about easing the suffering of individuals facing terminal illness. Rather, it was understood that to decriminalize these acts was to cross a significant threshold, a crossing that holds significant consequences for how we as a society value and understand life, our medical system and the duty of care we owe one another.

In both *Rodriguez* and *Carter* (paragraphs 2,33) the Supreme Court recognized the sanctity of human life as a fundamental value of Canadian society. Given the fundamental nature of the sanctity of human life in Canadian society and in the Court's deliberations, it should be referenced in the "Whereas" statements of Bill C-14. We appreciate the clause in the Preamble addressing the value of all lives, regardless of ability or disability, but feel a stronger statement is needed to reaffirm this objective.

- We suggest that the following language from the *Carter* decision be added as the first clause of the preamble:

  "Whereas the respect for life is one of our most fundamental societal values, and Section 7 of the Charter is rooted in a profound respect for the value of human life;"

Prevention of Suicide

The legalization of euthanasia and assisted suicide will have an impact on suicide prevention efforts and on rates of suicide generally. In the long term, this will change the way Canadians understand suffering and how they respond to it. We appreciate the statement in Bill C-14's preamble about suicide causing lasting harm, but given these concerns, the legislation should contain a stronger statement that acknowledges suicide is a tragedy that hurts families and communities. It should also include a clear statement that the prevention of suicide remains a crucial public policy objective.

---

[2] The Supreme Court of Canada, in *Rodriguez v. British Columbia*, recognized that Canadian society is "based upon respect for the intrinsic value of human life and on the inherent dignity of every human being." Mr. Justice Sopinka in that case referred to the sanctity of life as being one of the three *Charter* values protected in section 7 of the *Charter*. The Court, in *Carter*, acknowledged that "the sanctity of life is one of our most fundamental societal values" (para 63).

[3] Declaration on Euthanasia and Assisted Suicide (www.euthanasiadeclaration.ca).

- We recommend adding a statement that acknowledges suicide is a tragedy that hurts family and communities, as well as the following text, to the clause on the public health effects of suicide:

  "…and the prevention of suicide remains a crucial public policy objective."

Balance between Respect for Life and Autonomy

In *Carter*, the Supreme Court sought to achieve a balance between the government's interest in promoting and protecting life, and individual autonomy. *Carter* was not a "floor," as some have said, it was a delicate balance.

In *Carter*, the Court concluded that limited exceptions to the blanket prohibition, while inherently risky for vulnerable persons, could be balanced with the respect for life and not compromise it. To move beyond the *Carter* exceptions would further undermine the respect for life and increase the risk of a wrongful death.

- Following the clause on autonomy in Bill C-14, we recommend that the following be inserted:

  "Whereas Parliament has a duty to balance individual autonomy and the protection and promotion of life;"

Freedom and not an Obligation

It is our assertion that the Supreme Court did not establish a positive right to assisted suicide in the *Carter* decision; meaning it did not create an obligation for anyone to provide assistance. The Court found that a patient in specific circumstances and who meets certain criteria has a "right" to be free of the blanket state prohibition against assisted suicide and requesting assistance in suicide. The focus of the Court was on permitting a person in specific circumstances to seek assistance, and to receive assistance without being in violation of the *Criminal Code*. Thus, the Court offered an exemption from the prohibition, but did not mandate the provision of euthanasia and assisted suicide.

The Court did envision a "carefully designed and monitored system of safeguards" (para 117). However, the Court was explicit that its ruling is confined to the right (freedom) of someone to seek assistance, and not to those who might provide assistance (para 69). Neither Governments nor individuals are required to provide or fund access to assisted suicide or euthanasia under the *Carter* decision.

Hastened Death is not Health Care

Two clauses in Bill C-14's Preamble are problematic in that they describe and define medical assistance in dying as health care. These are the clauses that begin: ""Whereas it is desirable to

have a consistent approach to medical assistance in dying…" and "Whereas the Government of Canada has committed to uphold the principles set out in the *Canada Health Act*…" The very name "medical assistance in dying" indicates the same definition.

We object to the notion that to deliberately hasten a person's death can be considered health care. What the Court allowed for, and what Bill C-14 does, is to create exemptions to *Criminal Code* prohibitions against culpable homicide and assisted suicide, which is sole federal jurisdiction and must remain there. To define this as health care is to relinquish that jurisdiction, and we urge great caution on that point. Further, if hastened death is defined as health care and accepted as such, it will become very difficult to deny access to anyone, on any grounds. Such framing sets the legislation up for *Charter* challenge.

Eligibility

To minimize the harm to persons and to society, if Parliament proceeds with allowing the hastening of death, the *Carter* decision should be interpreted within the very narrow fact situation to which the Court was responding.

The Supreme Court in *Carter* expressly stated at para. 127: "the scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought."

The fact situations before the Court concerned individuals with terminal and degenerative conditions. The Court reasoned that persons who might find themselves physically unable at some point to take their own lives might end their lives prematurely if no assistance would be available to them later. The Court did not propose extending assistance to those who wished to end their lives and were capable of doing so. The focus was allowing assistance in suicide for those who would be physically incapable of taking their own life.

The Court used the description "grievous and irremediable medical condition" in the context of these specific fact situations. Following the reasoning of the decision, "grievous" would mean a person who is terminally ill, with a degenerative condition, who might choose to end their life prematurely if assistance to end their life would not be available to them later when their condition became intolerable.

In Bill C-14, one of the criterion of a grievous and irremediable medical condition is that a person's "natural death is reasonably foreseeable…" This provides a focus on those who are at the end of life, but allows room for subjectivity and, we suggest, abuse.

The House of Commons Justice Committee heard from many witnesses about how the term reasonably foreseeable is problematic. This is a concept imported from the law of civil and criminal negligence for after-the-fact determinations by a court as to whether a past action

attracts legal liability because its' negative consequences could have been foreseen and thus avoided. It is not an appropriate criterion in the context of hastened death. It lacks specificity and could be interpreted very broadly. As it is doctors and nurse practitioners who are the gatekeepers of eligibility under C-14, it is essential that the criterion be one that is medically understood and assessed, not an ill-fitting legal concept. We suggest that reasonably foreseeable be replaced with a specific time frame or with "at the end of life." While there is still imprecision and guesswork in either of these, they at least reflect the kind of assessment that doctors are accustomed to making, and are therefore more appropriate.

- In s. 241.2(2)(d), keep the focus on those who are dying, and replace "reasonably foreseeable" with one of the following:
    - "within reasonable medical judgment will produce death within 6 months,"[4] or
    - "at the end-of-life"[5]

Suffering

We are concerned that the condition of "suffering that is intolerable" to the individual in *Carter* and in C-14 is entirely subjective and, in fact, endangers the physician-patient relationship. This erodes the role of a physician in determining what treatment should be administered. As Dr. Cheryl Mack and Dr. Brendan Leier express in the *Canadian Journal of Anesthesiology*,

> Our fundamental concern is that the proposed model of PAD does not require medical expertise; rather, it requires capital in the form of physician trust to assure both patients and society as a whole that the intentional ending of life is a legitimate medical procedure overseen with the same care, diligence, and oversight as any technological or procedural advancement. This, however, is not the case. [6]

They go on to state: "With PAD, we are again being asked to endorse and sponsor a practice that relies neither on medical science nor on clinical judgment."[7] The Court inserts doctors into the equation, in fact, giving physicians the responsibility to end a life, but places the analysis regarding a "medical procedure" largely into the hands of the patient. This can marginalize and undermine the physician's medical expertise and judgment. The doctor becomes an extension of the will and autonomy of the patient, while still ultimately bearing responsibility for the act.

[4] Following precedent in Oregon and other U.S. states, and establishing a clear, medical standard.
[5] Following precedent of Quebec legislation.
[6] Cheryl Mack and Brendan Leier, "Brokering trust: estimating the cost of physician-assisted death," *Canadian Journal of Anesthesiology*, January 5, 2016.
[7] *Ibid.*

Further, pain and suffering are not the same thing. The question of suffering is beyond the scope of medicine alone. Pain is a physical question, which medical professionals are qualified to respond to and treat. But suffering is a broader human question, involving emotional, psychological, spiritual, social dimensions, and is beyond the expertise of medicine alone to address. The solution proposed by the Court to the problem of suffering not only fails to address the suffering, but eliminates the one who suffers. Suffering is properly addressed by good quality palliative care that considers the whole person and includes a range of supports.

Mental illness and psychological suffering, in the absence of a terminal, degenerative illness, should be expressly excluded from the eligibility criteria for hastened death. The *Carter* case did not address mental illness directly, as it responded to the specific fact situations of individuals with terminal and degenerative physical conditions. Persons experiencing mental illness are particularly vulnerable to suicidal ideation and mental illness often vitiates the ability to give informed consent to death.

The eligibility criteria must *not* be amended to include psychological suffering, in the absence of a terminal, degenerative illness. We recommend revising the eligibility criterion below to provide further protection for those with mental illness.

- In s. 241.2(2)(c), delete "or psychological" so that the provision describes a condition that causes "enduring physical suffering that is intolerable…."

Age

The Court used the term "competent adult" repeatedly and deliberately in the *Carter* decision. The Court is fully aware that there are differing provincial standards and ages of competence for care, but nonetheless chose to restrict the exemption to "adults," rather than "competent persons." Assisted death cannot be undone, it is intended to kill, and thus it cannot be considered like any other type of medical treatment.

We absolutely reject the notion that physician-assisted death be available to minors. Bill C-14 must *not* be amended to include mature minors.

Palliative Care

Underlying arguments for assisted dying is the exercise of autonomy, the exercise of choice. But without access to high quality palliative care there is no real choice in care options at the end of life. Without access to quality palliative care, people will be vulnerable to feelings of isolation, despair, to feeling like a burden to family or caregivers, and to the medical system.

In Oregon, in 2014, 40% of people who ended their lives under the *Death With Dignity Act* were concerned that they were a burden to family, friends/caregivers.[8] This has been a consistent percentage since 1998.

We concur with the report of the External Panel that there is an urgent need for improved access to excellent palliative care across Canada. The External Panel notes that it "heard on many occasions that a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person's suffering."[9] The report goes on to state:

> With the advent of physician-assisted death, it has become critically, even urgently, apparent that Canadian society must address its deficiencies in providing quality palliative care … Our country must rise to this challenge, as no Canadian approaching end of life should face the cruel choice between physician-assisted death and living with intolerable, enduring suffering in the absence of compassionate, comprehensive quality care.[10]

It is lamentable that we as a country are contemplating the decriminalization of assisted suicide in response to suffering when most Canadians do not have access to high quality palliative care and related support systems. Palliative care is best suited to provide comfort and care to patients and their families who are suffering and near death.

We recommend a palliative care or other professional assessment be mandated in Bill C-14, as part of the current safeguards. We also urge the government to establish a national strategy to address the availability of high quality palliative care.

- In s. 241.2(3) on safeguards, insert a clause that the medical practitioner or nurse practitioner must ensure that the person has had a palliative care or other professional evaluation to become informed about the full range of available treatments and supports that could ease their suffering, as recommended by the Vulnerable Persons Standard. This could be accomplished by either:

[8] Oregon Public Health Division, *Oregon's Death With Dignity Act – 2014.* https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

[9] External Panel, *Final Report*, p. vii.

[10] External Panel, *Final Report*, page 2.

- creating a subsection that says that in order for a patient to give "informed consent" in 241.2(1)(e) the patient must have been provided with the information/assessment; or
- adding a definition for "informed consent" in 241.1 that includes a palliative care or other professional evaluation.

- We affirm the recommendation of the Canadian Society of Palliative Care Physicians that the preamble be amended to include a commitment to the establishment of a National Palliative Care Secretariat.

Freedom of conscience

It is a violation of conscience to be compelled to take another person's life or to participate in the taking of a life. Health care providers must have the right to refuse to participate in physician-assisted suicide for reasons of conscience or religious belief, either directly or indirectly, including the right not to have to provide a referral.

The question of referral was not directly addressed in *Carter*. Providing a referral is, in effect, a professional recommendation for a course of treatment. In the case of physician-assisted suicide or euthanasia, it is a form of participation in an action that is destructive to the patient and is contrary to the deeply-held beliefs of many physicians.

In the Headnote of *Carter*, the Court said, "Nothing in this declaration would compel physicians to provide assistance in dying." Immediately following this assertion, the Court states that "The *Charter* rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment." These statements taken together indicate a need to reconcile the rights of patients and physicians without compelling objecting physicians to provide assistance, directly or indirectly. Bill C-14 should include a similar statement that nothing in the Act would compel health care providers to provide assistance in dying, as an assurance that its objective is not to compel health care providers to participate.

Hastened death is categorically different than end of life care, including palliative or continuous sedation in the last days or hours of a patient's life. The intention to end a life, rather than to alleviate pain, makes euthanasia and assisted suicide fundamentally different than end of life care.

As well, many faith-based institutions provide senior care, extended care and hospice care. The care they offer is an expression of the deeply held beliefs of the communities that provide the care. To compel these institutions to facilitate or allow assisted death on their premises denies the beliefs that animate their compassion. Health care professionals, staff and the

administrators of these facilities should not be compelled to participate in or facilitate assisted death, and these facilities should be able to obtain an exception if Parliament proceeds.

The Justice Minister has said the legislation does not compel a medical professional to participate. While participation or referral are not specifically required in the legislation, the Minister has stated that MAID is now considered necessary medical treatment. The College of Physicians and Surgeons of Ontario is requiring effective referral.[11] This places conscientious objecting persons and institutions at risk of coercion. At best, *Carter* established a right in some circumstances to be free from the blanket prohibition. Establishing a positive right to access establishes a corresponding obligation.[12] If the premise that MAID is a right is accepted, there will be an obligation to protect the freedoms of health care providers and institutions that object on grounds of religion or conscience.

- To enshrine conscience protection in Bill C-14, we recommend inserting the following clauses in the Preamble:
  "Whereas everyone has the freedom of conscience and religion under section 2 of the Canadian *Charter of Rights and Freedoms*;

  Whereas freedom of religion under the *Charter* accounts for the socially embedded nature of religious belief, and the deep linkages between this belief and its manifestation through communal institutions and traditions;

  Whereas nothing in this Act affects the guarantee of freedom of conscience and religion and, in particular, the freedom of all persons and health care institutions to decline to participate directly or indirectly in the provision of medical assistance in dying if doing so is against such person's religious beliefs or conscience, or contrary to an institution's purposes.

  Whereas it is not against the public interest to hold and publicly express diverse views on medical assistance in dying;"

[11] CPSO Policy on Professional Obligations and Human Rights, http://www.cpso.on.ca/Policies-Publications/Policy/Professional-Obligations-and-Human-Rights

[12] The Court did not find a substantive right to assisted suicide. Rather they felt that in limited situations persons should be exempt from the blanket prohibition and that a willing physician should not be prosecuted for assisting them. The exemptions created a freedom to seek and receive assistance, not a right to which others are obligated to provide.

This right to conscience protection is fundamental, and concerns about access to hastened death do not remove the obligation to accommodate conscience rights. We support the creation of a self-referring central agency to facilitate conscience protection for health care providers; however, it is still crucial to provide conscience protection for individuals and institutions in the legislation.

This legislation will set the criminal law floor for medical assistance in dying across the country. Provinces may not pass legislation on medical assistance in dying, leaving regulation to existing health laws and the provisions established through Bill C-14. It is therefore imperative that Bill C-14 include conscience protection.

Some have argued it is unnecessary to include conscience protection in the legislation, but to do so as a guarantee would do no harm. Rather, it would clarify the intent of the legislation and it would alleviate the concerns of many Canadians.

- We recommend the following be inserted as a standalone provision of C-14, in a new section before Related Amendments, or as an amendment to the *Canada Health Act*:

  Freedom of Conscience
  For greater certainty, no person or organization is required to participate directly or indirectly in the provision of medical assistance in dying, and no person or organization shall be deprived of any benefit, or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise, in respect of medical assistance in dying, of the freedom of conscience and religion guaranteed under the *Charter of Rights and Freedoms*.

With respect to coercion, we note that federal legislation provides protection from coercion in other contexts. For example, the *Status of the Artist Act* provides protection from being intimated or coerced to become a member of an artists' association. The *Banking Act* forbids a bank from coercing someone to obtain a product or service from a person or bank as a condition of obtaining another service or product. Surely the consciences of medical professionals and institutions can be protected from being coerced to facilitate the death of another.

- The government could create a *Criminal Code* offence that prohibits the coercion of any person to apply for, seek or receive MAID, and prohibits coercion of health care

providers and institutions to counsel in relation to, or to participate directly or indirectly in MAID.[13]

Safeguards

Euthanasia and assisted suicide are fraught with risk, particularly for the vulnerable. The lower court in *Carter* concluded that the "risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced." Yet the trial judge also acknowledged that some evidence on the effectiveness of safeguards was weak, and there was evidence of a lack of compliance with safeguards in permissive jurisdictions. (par. 105 and 108).

Parliament needs to carefully assess whether the Court is correct to assume safeguards will be adequate to eliminate the possibility of a wrongful death. The experience of other permissive jurisdictions shows that safeguards have not prevented wrongful deaths.

In *Carter*, the Court maintained that the risks associated with physician-assisted suicide can be limited through a carefully designed and monitored system of safeguards (para. 117). When dealing with matters of life and death, we are concerned with the low threshold denoted by the word "limited." In contrast, the opposition to capital punishment turns on the fear that a wrongfully convicted person might be put to death. The threshold is set very high. What is our tolerance for safeguard failures in the context of assisted death? We ask for the threshold to be set high in the context of medical assistance in dying as well.

The Court envisioned stringent safeguards because these were necessary in the balancing of autonomy and protection of life. While we believe assisted death should not be allowed, if it is established, exemptions should ensure that occurrences of physician-assisted suicide and euthanasia are rare, in order to minimize the harm to persons, to our societal commitment to respect for life and to our health care and social systems. Very strict safeguards must be put in place to protect the vulnerable; both those made vulnerable because of a grievous medical condition and those whose vulnerability pre-existed any grievous medical condition.

Advance Directives

It is a critical safeguard for the patient to be competent at the time of the medical assistance in dying. Bill C-14 must *not* be amended to allow for advance directives.

[13] For examples of such legislation, see Bill C-268, An Act to Amend the Criminal Code (medical assistance in dying), or the Protection of Conscience Project proposal at http://www.consciencelaws.org/publications/submissions/submissions-025-001-parl.aspx

Judicial Oversight

As an additional safeguard, Bill C-14 should require independent prior review of all cases of hastened death. One way to do this would be to extend the current requirement for judicial oversight established by the Supreme Court when the deadline was extended.

The Justice Committee heard testimony about the efficiency of Consent and Capacity Boards in certain provinces, which might be another model. The key is prior review of each case, by more than just the two assessing physicians or nurse practitioners, as a means of safeguarding the patient, the physicians and the health care system. Whether it is by judicial oversight or some other mechanism, we recommend that a straightforward, efficient system can and should be developed for independent prior review.

Exemption for Aiding a Patient

The Exemption for a person aiding a patient in s. 241(5) is not subject to any oversight, could conceivably apply to any person, and raises serious risks of undetected abuse. The exemption should either be removed or amended. If not removed, the legislation should impose an obligation on the person seeking the exemption to take reasonable steps to confirm that the suicide is authorized and the substance has been provided under s. 241.2, such as seeing the written request and the doctor's certifications under 241.2. The legislation must include some form of oversight to provide protection for the patient and confirmation of consent.

Regulations

We recommend that s. 241.31(3) be amended to read: "The Minister of Health *will* make regulations…"

Further, data collection should include the reasons for requesting assisted death, similar to what is required by the Oregon legislation.

Conclusion

With Bill C-14, Canada takes another step in crossing a significant threshold. The decriminalization of euthanasia and assisted suicide constitutes a fundamental shift in how we as a society value and understand life, and the duty of care we owe one another. Never before have we said as a nation that the intentional taking of a life is an appropriate response to suffering, or that some lives are not worth living. The weight of the decision before you cannot be overstated. We plead with you to make protection of the vulnerable and respect for human life paramount in your considerations.