EFC The Evangelical Fellowship of Canada

Summary of the Evangelical Fellowship of Canada's Submission to the Special Joint Committee on Physician-Assisted Dying

Principles

Respect for life and care for the vulnerable are principles that have shaped Canadian law historically and were recognized by the Supreme Court in the *Carte*r decision. Respect for life 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. **On the basis of our beliefs and commitment to the sanctity of human life, we are unequivocally opposed to both assisted suicide and euthanasia.**

Balance between Respect for Life and Autonomy

In *Carter*, the Supreme Court sought to achieve a delicate balance between the government's interest in promoting and protecting life, and individual autonomy. **To treat the decision as a floor, as some have suggested, and allow more expansive access to assisted dying is to misunderstand the balance the Supreme Court was seeking to achieve.**

Parliament has a duty to assess this balance to determine whether the protection and promotion of life will be undermined by any exemption to the prohibition on assisted suicide. It has the authority to reject the Court's decision, or in legislation to reaffirm its purpose of promoting life (a purpose the Supreme Court sidestepped because they acknowledged that a complete ban on assisted suicide was justifiable if the purpose was protecting life). As *Carter* proposes a *Criminal Code* exemption, Parliament has the jurisdiction to assess whether the Court was correct to assume that limited exemptions on assisted suicide and euthanasia would not undermine its purpose for the prohibition.

Freedom and not an Obligation

The Court found that a patient who meets certain criteria should have the freedom to seek and receive assistance in suicide. While the Court offered a limited exemption from the prohibition, it did not mandate the provision of euthanasia and assisted suicide. **Neither Governments nor individuals are required to provide or fund access to assisted suicide or euthanasia under the *Carter* decision.**

Eligibility

If Parliament proceeds with allowing the hastening of death, the decision should be interpreted within the very narrow fact situation in *Carter.* The focus of the Court was allowing assistance in suicide for those with terminal and degenerative conditions who would be physically incapable of taking their own life without assistance.

- Following the reasoning of the decision, "grievous" should be defined in federal statute as 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 they would need it.

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- As an additional safeguard, “grievous and irremediable” should apply only to situations where it is beyond the capacity of palliative care to manage pain.
- Mental illness and psychological suffering must be expressly excluded.

Suffering

We are concerned that the Court’s condition of “enduring suffering that is intolerable to the individual” is entirely subjective and, in fact, endangers the physician-patient relationship. 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.

Age

The Supreme Court is fully aware that there are differing provincial standards and ages of competence for care, but nonetheless chose to restrict the exemption to “competent adults,” rather than “competent persons.” Adherence to *Carter* requires restricting access to competent adults. **We absolutely reject the Provincial-Territorial Expert Advisory Group recommendation not to implement age restrictions, which would leave the door open to minors requesting physician-assisted death.**

Choice

Underlying arguments for assisted dying is the exercise of autonomy, the exercise of choice. To offer assisted suicide as an option when so many Canadians lack proper access to high quality palliative care constitutes a hollow choice at the end of life. **There is an urgent need for improved access to excellent palliative care across Canada.**

- We urge the government to establish a national strategy to address the availability of high quality palliative care.

Freedom of conscience

- Physicians must have the right to refuse to participate in physician-assisted suicide for reasons of conscience, either directly or indirectly, including the right not to have to provide a referral.
- Health care professionals, staff and administrators of faith-based 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.

Safeguards

The Court envisioned stringent safeguards to limit the risks inherent in physician-assisted dying. Parliament must study carefully whether it is possible to establish *effective* safeguards and must also determine the level of acceptable risk of a wrongful death. **We believe assisted suicide should not be allowed, but if it is established, it is essential to put in place stringent safeguards, scrupulously monitored and enforced.**

Essential safeguards include: access to high quality palliative care; federal statute establishing definitions, eligibility criteria, the process of request and the requirement of a judicial warrant; a federal agency to regulate and monitor the practice; physicians participating in assisted dying be licensed by a federal regulatory body; robust pre-assessment of the patient and the request, which could include assessment by two physicians and/or a multi-disciplinary committee chaired by a judge; a rigorous process to determine competence and consent; a waiting or cooling off period; repeated, voluntary, documented requests by the patient; and requirement that the patient be competent at the time of the assistance.

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