EFC The Evangelical Fellowship of Canada

A Brief Analysis of the Report of the Special Joint Committee on Physician-Assisted Dying

On February 25, the Special Joint Committee on Physician-Assisted Dying released its report to Parliament. The majority report makes 21 recommendations on how the federal government should address assisted suicide and euthanasia. Many, if not most, of the recommendations are deeply troubling.

Having attended all of the committee hearings that were open to the public, we are sadly not surprised by the recommendations. However, we had hoped the committee would heed the cautions of the many witnesses who urged restraint.

The EFC maintains complete opposition to euthanasia and assisted suicide, based on our beliefs in the sanctity of human life. But we are engaging in the public and political discourse to ensure that occurrences of assisted death are rare, that the inherent risks and harms associated with the practices are minimized, and to seek the strongest protections for those who are vulnerable.

Now is a critical time to engage with government on this issue. The committee's recommendations to Parliament fail to meet the Supreme Court's standard of stringent safeguards that are scrupulously monitored and enforced to protect those who are vulnerable. Evidence from other jurisdictions that have allowed assisted death shows that no safeguards are fully effective, but the committee's proposed safeguards are wholly inadequate in this regard.

Further, the committee is recommending far more expansive access to assisted death than the Supreme Court provided in the *Carter* decision. In *Carter*, the court sought to strike a delicate balance between the government's interest in promoting and protecting life, and individual autonomy. The EFC argued that to treat the decision as a floor and allow more expansive access to assisted death, as the committee has, is to misunderstand and disrupt the balance the court was trying to achieve. The court believed that allowing limited exceptions to the blanket ban on assisted suicide would not compromise our society's respect for life, nor expose vulnerable persons to the risk of wrongful death. Yet, as we noted in our submission to the committee, there have been wrongful deaths in jurisdictions that allow assisted death.

Illness does not have to be terminal, or physical

The committee does not restrict euthanasia and assisted suicide to people at the end of life, with a terminal illness, or to those who have a physical illness. If Parliament strictly followed the Supreme Court's decision, it would limit eligibility to a competent adult who is terminally ill, with a degenerative physical condition, near the end of their life and who

might choose to end their life sooner if assistance would not be available to them when their condition became intolerable and they would be unable to take their own life.

Further, the committee recommends that the government not define in law what it means to have a grievous and irremediable condition. Instead, they suggest that determination be left up to doctors. This is troubling because the terms are vague. In practice, there is no clear definition or understanding. According to the report of the Federal External Panel, the executive director of the College of Family Physicians of Canada indicated that different physicians strongly express different views on what the terms should mean. She communicated to the panel that among a diverse group of family physicians, consensus on this definition would be difficult to reach.

To leave it to physicians to determine what constitutes a grievous and irremediable medical condition places a heavy burden on the physician. It will also be impossible to ensure strict national standards and criteria if these terms are not defined in federal law.

Mental health

The committee recommends that individuals with a psychiatric condition should be eligible for assisted death, even in the absence of a physical illness. They also recommend that psychological suffering – again, whether or not physical illness is also present – be recognized as a criterion for assisted death. And they do not require psychiatric assessment of patients with psychiatric conditions, or whose suffering is psychological.

These recommendations are contrary to testimony the committee heard from both the Canadian Psychiatric Association and the Canadian Association for Mental Health. Persons experiencing mental illness are particularly vulnerable to suicidal ideation, and the committee's recommendations fail to offer any protection.

As Dr. Sonu Graind of the Canadian Psychiatric Association told the committee:

> Mental illnesses can affect cognition and impair insight and judgment. Symptoms of cognitive distortions common with clinical depression include negative expectations of the future; loss of hope; loss of expectation for improvement, even when there may be realistic hope for positive improvement; loss of cognitive flexibility; loss of future-oriented thought; and selective ruminations focused on the negative and minimizing or ignoring the positive. There are commonly distortions of a person's own sense of identity and role in the world, including feelings of excessive guilt and worthlessness or feeling like a burden to others.[1]

[1] *Evidence*, Special Joint Committee on Physician-Assisted Dying, January 27, 2016. www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8075735#Int-8772474

Dr. Graind went on to say, "I want to emphasize that none of this is to suggest that simply the presence of any mental illness alone impairs people's judgment and cognition, but in the PAD discussion, by definition, we are talking about the most severe situations, and in severe cases of mental illness, the risk of such cognitive distortion is, of course, higher. We think with our brains, not with our hearts or limbs."

The Canadian Psychiatric Association recommended that when a person with a psychiatric illness requests physician-assisted death, that multiple assessments over time be carried out by those with suitable skill sets to ensure that nuanced issues that could affect decision-making are properly assessed and to allow time for potential remediation of symptoms and/or psychosocial factors.

Similarly, Dr. Tarek Rajji of the Centre for Addiction and Mental Health told the committee:

> …there must be safeguards in place to ensure people with mental illness truly have the capacity to consent to PAD. … When a person is experiencing an acute episode of their illness such as a major depressive episode, or an acute psychotic episode, or a manic episode, it's not uncommon for them to have severely distorted beliefs about themselves, the world, and their future. Sometimes the sense of helplessness, and worthlessness, and hopelessness continues even when the symptoms of the mental illness are better controlled.[2]

Dr. Rajji went on to say:

> I think it's critical to have a comprehensive capacity assessment for someone who has a mental illness but is suffering from a non-mental illness which could be the grievous and irremediable condition. …, I think it would be critical to evaluate whether the request for PAD, for example, is being driven by the mental illness itself or the view of their physical illness as influenced by the mental illness.

Age

The committee recommends a two stage implementation, with assisted death made available initially to those 18 years of age and older, and extended to mature minors within three years. This means that mature minors – children and teens who may be viewed as competent to make certain decisions related to their own medical care – would be given the ability to request their own death.

The Supreme 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

[2] *Evidence*, Special Joint Committee on Physician-Assisted Dying, February 3, 2016. www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8084555

ages of competence for health 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 cannot be considered to be just like any other type of medical treatment.

With respect to children, the Canadian Paediatric Society argued that the committee should not go beyond the Supreme Court's pronouncement. As Dr. Mary Shariff of the Canadian Paediatric Society told the committee, "…there is a massive ethical question as to whether children and adolescents should be able to qualify in the first instance for lethal injection. This ethical question was not considered in Carter, and to the best of my knowledge, it has not been fully considered by Canadians."[3]

Conscience

The committee agrees with the court that physicians who object to euthanasia and assisted suicide should not be required to perform "medical assistance in dying." However, the committee recommends that those physicians should be required, at a minimum, to make an effective referral for a patient requesting assisted death. For some doctors who object on the basis of conscience/deeply held beliefs, to make a referral is to participate in the taking of a life. We are concerned that conscience protections will not extend to these, and they will be faced with the choice of violating their conscience or being disciplined by their professional body. It is notable that no other jurisdiction that allows euthanasia and assisted suicide requires objecting physicians to refer.

As Dr. Jeff Blackmer of the Canadian Medical Association told the committee:

> For other physicians, however, making a referral for assisted dying would be categorically, morally unacceptable. For these physicians, it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, being asked to make a referral for assisted dying respects the conscience of some physicians, but not of others.[4]

Dr. Blackmer went on to say, "In fact, we have a very small percentage of members who said they feel very conflicted about the obligation to refer; however, the entire rest of the profession says that even though they may not share that view, they will fight for the right of the others to not have mandatory referral. …The final point I would make on that, which I think is critically important, is that no other jurisdiction in the world has mandatory effective referral."

We are also very concerned about the lack of conscience protection afforded for institutions that object to euthanasia and assisted suicide. In fact, the committee

[3] Evidence, February 3, 2016.
[4] Evidence, January 27, 2016.

recommends that the government *ensure* that all publicly funded institutions provide these services. Many faith-based hospitals, extended care facilities and hospices receive varying degrees of government funding, and if the committee's recommendation is followed, would be compelled to provide assisted death within their facilities.

As Cardinal Collins, Archbishop of the Archdiocese of Toronto, said to the committee:

> In light of all this, it is clear that reasonable people, with or without religious faith, can have a well-founded moral conviction in their conscience that prevents them from becoming engaged in any way in the provision of assisted suicide and euthanasia. They deserve to be respected. It is essential that the government ensure that effective conscience protection be given to health care providers, both institutions and individuals. They should not be forced to perform actions that go against their conscience or to refer the action to others, since that is the moral equivalent of participating in the act itself. It's simply not right or just to say, "You do not have to do what is against your conscience, but you have to be sure it happens.[5]

With respect to the right of institutions who conscientiously object to refuse to provide assisted death, some pro-euthanasia witnesses argued before the committee that "bricks and mortar do not have a conscience," and therefore that all institutions receiving public funding should be required to provide euthanasia and assisted suicide.

Cardinal Collins went on to say:

> I think it's very true to say that institutions are not bricks and mortar.... Institutions are made of people. Institutions are like the Sisters of St. Joseph, the Grey Nuns, all of the various groups who have brought loving health care to this place. They're not things; they're communities of people. They have values, and that's why people come to them. That's why they seek them out. These institutions are funded by the government because they do immensely good work. They provide a variety, diversity, choice, I might say, to people, and that's very, very important. If you undermine the institution for what it is, our society will be very much harmed. Our whole community would be a lot harsher, colder, crueller, without the witness given by communities of faith who are on the ground, on the street, day by day, caring for the most needy. I don't think they should be undermined or attacked.

Advance Directives

The committee recommends allowing advance directives for people who have been diagnosed with a medical condition that may become grievous and irremediable. This

[5] Evidence, February 3, 2016.

would mean that a patient wouldn't have to give consent, or be competent to give consent at the time of their assisted death. The Canadian Medical Association testified before the committee that implementing advance directives is "incredibly difficult and complex" at the best of times, and felt that they should not permitted for assisted death. The committee also heard that in Quebec, advance directives for assistance in dying were considered, but not included in their legislation because they chose to prioritize protection of the vulnerable.

Dr. Blackmer of the Canadian Medical Association spoke to the committee about advance directives:

> What I can tell you is that in real-life practice, putting advance directives into action is incredibly complex and difficult, because it's very hard to capture all of the nuances and the specifics of a very complicated medical condition and intervention. Even in the best of situations, physicians have a lot of difficulty actualizing an advance directive.
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> What our members have told us is that they see a lot of potential difficulties if we were to layer on the concept of providing advance directives with a very complex set of circumstances in this type of novel intervention, especially right out of the gate. It would, again, be one further level of complexity that would make it more difficult for a lot of physicians to participate and to actualize the assisted dying process.[6]

No prior review or approval

The committee recommends that two independent physicians confirm a patient's eligibility for assistance, but don't recommend any pre-assessment beyond this. In fact, they recommend that the government work with provinces and territories to ensure that there is no prior review and approval process required.

Palliative care

While the committee does recommend some good measures on palliative care toward the end of the report, the nod given to the issue is not sufficient to ensure people have real choice at the end of life. The measures they suggest are essential, and ones we recommend and support, but they will not effect change quickly. As noted in the report of the Federal External Panel, "A request for physician-assisted death can not be truly voluntary if the option of palliative care isn't available to alleviate a person's suffering."

Mr. Gabriel Miller of the Canadian Cancer Society noted the significant gaps in palliative care provision in Canada, and told the committee, "Palliative care doesn't have the same

[6] Evidence, January 27, 2016.

complexity as assisted dying. It is simply the notion that people should be well cared for – as people – to minimize their suffering and maximize their enjoyment of life. The only enduring mystery is how Canada has failed for so long to fix its broken palliative care system."[7]

He also noted that "Any serious conversation about the needs of severely ill Canadians must include palliative care, and any responsible policy on assisted dying must guarantee access to quality palliative care for all Canadians."

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. Assisted death must not be the only choice.

A Critical Time to Act

As we respond to the committee report, we will continue to uphold the sanctity of life and protect the vulnerable. We ask for your prayers. Pray for us as we meet with MPs and Senators, and work with like-minded faith-based and secular groups to minimize the harms and inherent risks of going down this path. Pray for the legislators who will be making decisions about how to proceed.

Educate those within your circle of influence, and encourage them to pray and to communicate with their local MPs, and with Senators from their province. The EFC has developed resources to inform and equip people on these issues (see www.theEFC.ca/EuthanasiaUrgentAction).

Continue to encourage people to sign the Declaration against Euthanasia and Assisted Suicide, developed by the EFC and the Canadian Conference of Catholic Bishops (see www.euthanasiadeclaration.ca).

Lastly, as Christians, we are to protect the vulnerable, to care for the sick and dying and to walk with those who are in the valley of the shadow of death. May we be faithful witnesses and agents of God's love.

[7] Evidence, Special Joint Committee on Physician-Assisted Dying, February 1, 2016. www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8080880#Int-8776633