

# Submission to the Special Joint Committee on Physician-Assisted Dying

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### **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.

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*. In 2015, we made oral and written submissions to the External Panel on Options for a Legislative Response to *Carter v. Canada* and a written submission to the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. We have also made submissions to various Parliamentary committees and legislative initiatives on related issues since the 1990s. This past fall, 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 13,000 signatories to date, including evangelical, Catholic and Orthodox leaders, and more than 20 Jewish and Muslim leaders from across Canada.<sup>1</sup> We have produced many resources on the legal, ethical and moral dimensions of euthanasia and assisted suicide.

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.

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

Law and public policy are shaped and animated by norms, principles and values. As an association of evangelical churches and organizations, our perspective is grounded in our Christian faith. We seek to engage with other Canadians on the meaning and implications of these shared principles. In this submission, we seek to be advocates for the respect for life and care for the vulnerable; two principles that we affirm from out of our faith tradition and which have shaped Canadian law historically, and which were recognized by the Supreme Court in the *Carter* decision. Societies and cultures around the world and throughout history share a reverence for human life and a belief in the equal and inviolable dignity of every human being. These are not exclusively religious beliefs. The sanctity of human life, or respect for life, is

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<sup>1</sup> Declaration on Euthanasia and Assisted Suicide ([www.euthanasiadeclaration.ca](http://www.euthanasiadeclaration.ca)).

broadly recognized and affirmed by all Canadians, including those who are adherents of specific religions and those who claim no adherence.

The sanctity of human life is a foundational principle of Canadian society.<sup>2</sup> 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.<sup>3</sup>

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 because 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.

### ***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. Parliament has a duty to assess this balance to determine whether the protection and promotion of life will be undermined. We argue that to treat the decision as a floor, as some have suggested, and allow more expansive access is to misunderstand the balance the Supreme Court was seeking to achieve.

In *Carter*, the Court acknowledged the Federal Government had two purposes in banning assisted suicide; one was protection of the vulnerable, the other was the promotion or preservation of life. The Court decided not to consider the purpose of the preservation of life, reasoning that to define the objective of the prohibition as the preservation of life had the potential to "short circuit" the analysis (para 77). The Court acknowledged that a complete ban on assisted suicide was justifiable if the purpose of the ban was to preserve life (para 77 and 78). The Court instead focused on the other purpose of protecting the vulnerable. Parliament is within its jurisdiction to assess whether the Court was correct to assume that limited

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<sup>2</sup> 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).

<sup>3</sup> Declaration on Euthanasia and Assisted Suicide ([www.euthanasiadeclaration.ca](http://www.euthanasiadeclaration.ca)).

exemptions to the blanket prohibition on assisted suicide and euthanasia would not undermine its purpose for the ban. Parliament has the authority to reject the Court's decision, or to re-assert its purpose of promoting life and re-affirm a complete ban on assisted suicide.

Parliament is also within its jurisdiction to 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.

If Parliament decides to proceed with the *Criminal Code* exemptions provided for in *Carter*, it is imperative to err on the side of caution to protect vulnerable persons and the sanctity of human life. While we disagree with the Court's decision to allow for exemptions to the blanket ban on assisted suicide, we recognize that the Court sought to achieve a delicate balance. More expansive access to assisted dying would further compromise the societal norm of the sanctity of human life that animates our health care and social welfare systems and would place more people at risk. If Parliament decides to cross this threshold, we urge you to craft exemptions in such a way as to 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.

### ***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 focused on patient autonomy, the freedom to request assistance, and the freedom of a doctor to assist, not on the provision of assisted suicide. The implication of the ruling is that a willing physician who freely assists an eligible patient in their suicide would also be free from the prohibition. 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.

## **Eligibility**

### *Grievous and irremediable*

To minimize the harm to persons and to society, if Parliament proceeds with allowing the hastening of death, the decision should be interpreted within the very narrow fact situation to which the Court was responding. In para 127 of the decision the Court stated, “The scope of the declaration is intended to respond to the factual circumstances of this case.” 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 of the Court 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” means 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.

The term “grievous and irremediable medical condition” must be defined by federal statute in order to ensure strict national standards. Without this, the term itself leaves far too much room for subjectivity, and, we suggest, abuse. As the External Panel heard, a consensus would be difficult to reach among family physicians on the meaning of the terms.<sup>4</sup>

As an additional safeguard, we also suggest that “Grievous and irremediable” should be qualified to apply only to situations where it is beyond the capacity of high quality palliative care to manage pain and suffering.

With respect to mental illness, we note the concerns raised by the Government in *Carter*, and those presented to the Committee by other witnesses. The Government of Canada argued that sources of possible error and factors that can render someone “decisionally vulnerable” include depression and other mental illness (para 114). In the Committee hearings, the Canadian Psychiatric Association and the Centre for Mental Health expressed serious reservation about including mental illness as a criterion. We urge you to err on the side of caution and not include mental illness or psychological suffering in the eligibility criteria for physician hastened death.

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<sup>4</sup> External Panel on Options for a Legislative Response to *Carter v. Canada, Consultations on Physician-Assisted Dying: Summary of Results and Key Findings, Final Report*, page 57.

### *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. 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.<sup>5</sup>

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."<sup>6</sup> 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.

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.

It is critical that psychological suffering be expressly excluded from any definition of "grievous and irremediable."

### *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.

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<sup>5</sup> Cheryl Mack and Brendan Leier, "Brokering trust: estimating the cost of physician-assisted death," *Canadian Journal of Anesthesiology*, January 5, 2016.

<sup>6</sup> *Ibid.*

In Canada, the age of majority is the age at which a person is considered by law to be an adult. This age is either 18 or 19, depending on the province or territory. The Canadian Hospice Palliative Care Association recommended to this Committee that adult be defined as someone who is at least 21. 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. But without access to high quality palliative care there is no real choice 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. Assisted death must not be the only choice.

Choice is also limited if the social determinants of health are not present. People who lack access to water, food and affordable housing, and who may lack social support and family assistance do not have meaningful choices.

Meaningful choice also includes having support available. 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.<sup>7</sup> 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.”<sup>8</sup> 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 for individuals living with life threatening and life limiting conditions. 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.<sup>9</sup>

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<sup>7</sup> Oregon Public Health Division, *Oregon’s Death With Dignity Act – 2014*.

<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

<sup>8</sup> External Panel, *Final Report*, page vii.

<sup>9</sup> External Panel, *Final Report*, page 2.

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 urge the government to establish a national strategy to address the availability of high quality palliative care. As an association of churches, we are encouraging churches across Canada to consider how they might engage in providing care, comfort and support for their neighbours who are living with terminal illness or severe disability.

### ***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. In the Headnote of *Carter*, the Court said, “Nothing in this declaration would compel physicians to provide assistance in dying.”

The question of referral was not directly addressed in *Carter*. It is important to understand that 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.

The Court’s statement, “The *Charter* rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment” immediately follows the assertion, quoted above, that “Nothing in this declaration would compel physicians to provide assistance in dying.” 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.

There is a reason why the medical professionals who are closer to the direct care for people at the end of life are more opposed to the practice of assisted death. They believe it 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.

It is a violation of conscience to be compelled to take another person’s life or to participate in the taking of a life. This right to conscience protection is fundamental. If there are concerns about patient access to physician hastened death, we urge you to seek a resolution that does not violate conscience.



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.

### ***Safeguards***

The practice of euthanasia and assisted suicide are fraught with risk, particularly for the vulnerable. Parliament must study carefully whether it is indeed possible to establish effective safeguards and must also determine the level of acceptable risk of a wrongful death. The lower court in *Carter* concluded that the “risks inherent in permitting physician-assisted death can be identified and very substantially minimized.” 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 (para 105 and 108). Our review of studies of the effectiveness of safeguards used in permissive jurisdictions indicates that no safeguards are completely effective.

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 this context? We ask for the threshold to be set high in the context of assisted suicide as well. If we set the bar lower than our standards for wrongful death or murder, we communicate that the lives of those with grievous and irremediable medical conditions are less valuable and less worthy of protection.

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, very strict safeguards must be put in place to minimize the harm to our societal commitment to the respect for life and to protect the vulnerable; both those made vulnerable because of a grievous medical condition and those whose vulnerability pre-existed any grievous medical condition.

As mentioned earlier, one of these safeguards must be to ensure that psychological suffering, in the absence of a terminal, degenerative illness, is expressly excluded from the eligibility criteria.

Effective safeguards are essential now, but also in light of Canada's aging population. In 15 years, almost 1 in 4 Canadians will be over the age of 65, and there will be a significant strain on the health care system.

Essential safeguards include:

- Access to high quality palliative care.
- A waiting or cooling off period for people recently diagnosed with a life threatening condition or who have suffered a traumatic injury.
- The patient must be competent at the time of the assistance.
- Federal statute establishing definitions (such as grievous and irremediable), eligibility criteria, assessment of competency, definition of consent, the process of request, and the requirement of a judicial warrant to proceed.
- The practice should be regulated and monitored by a federal agency. We suggest that physicians participating in physician-assisted dying should be licensed under a federal regulatory body.
- A rigorous process to ensure competence and voluntariness, to ensure the patient is making a fully-informed decision without coercion.
- The patient must make repeated, voluntary, documented requests. There should be a waiting period between requests.
- Robust pre-assessment of the patient and the request, which could include assessment by a minimum of two physicians and/or a pre-review committee that is multidisciplinary and chaired by a judge.

### ***Conclusion***

We plead with you to make protection of the vulnerable and respect for human life paramount in your considerations.