



EFC

The Evangelical
Fellowship of Canada

Submission of the Evangelical Fellowship of Canada
to the Council of Canadian Academies
on

Medical Assistance in Dying in Canada

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Q1. What are your organization’s main issues concerning requests for MAID by mature minors, advance requests, and/or where mental illness is the sole underlying medical condition?

The Evangelical Fellowship of Canada (EFC) is the national association of evangelical Christians in Canada. The EFC upholds respect for human life and care of vulnerable persons. Expanding access to euthanasia and assisted suicide (EAS) would place the most vulnerable Canadians at risk and further undermine societal respect for life.

Human life has intrinsic worth. Allowing EAS communicates that some lives are less valuable than others.

The requirements and guidelines to fulfill in order to perform EAS can lack clarity even in cases not involving mental illness, mature minors or advance requests. These potentially more complicated cases, involving some of the most vulnerable of Canadians, would increase the potential for abuse and would be even more difficult to govern.

Mental illness

Canadians affected by mental illness are a vulnerable and stigmatized population.

Persons experiencing mental illness can be particularly vulnerable to suicidal ideation. As Broome and de Cates’ said of depression, “Indeed hopelessness, closure of the future, and suicidal ideation are key features of the illness” (2015, p. 587).

Mental illness may vitiate the ability to give informed consent to death (S. Kim & Lemmens, 2016). An article that noted evidence from clinical ethics and empirical studies indicating that decision-making capacity is often impaired in those with severe depressive illness, went on to recommend: “In contrast to other areas where capacity is assumed as a default, that in these cases it should be assumed to be absent unless assessed thoroughly” (Broome & de Cates, 2015, p. 587).

Capacity can be difficult to assess. A study by Kim, De Vries and Peteet of psychiatric EAS cases in the Netherlands, from 2011 to 2014, indicated there was a disagreement among the consultants in one-quarter (24%) of the requests (2016, p. 362). The study goes on to note that EAS proceeded with the disagreements unresolved for most cases.

Research and resources on evaluating capacity are lacking (S. Kim & Lemmens, 2016, p. E338).

The preservation of hope is absolutely paramount (Park & Chen, 2016, p. 34). However, extending the option of euthanasia or assisted suicide (EAS) implies there is no hope of recovery.

One of the key problems that arises with respect to euthanasia in patients with intolerable suffering due to a psychiatric condition, as noted by Vandenberghe, is that “The process of carefully evaluating a euthanasia request inevitably takes time, in the meantime undermining hope and orientation toward life, both crucial to safeguard the chances for partial recovery” (2012, p. 1).

Mental illness may not follow a predictable progression. As well, with depression, for example, remission is always a possibility and there is hope as new treatments are developed (Whitley, Palmer, & Gunn, 2015).

Mental illness is experienced by many in Canada, but there is limited treatment available. As a nation, we must not offer death in the absence of treatment.

Mature minors

The EFC absolutely rejects the idea that EAS should be made available to minors.

Children are a vulnerable population. Canada’s first priority must be to provide high quality medical care for children. To consider expanding EAS to mature minors in the absence of widely available, high quality mental health services and palliative care would be unethical.

Even within Canada, across provincial jurisdictions, the age of consent for medical treatment varies. There is no agreement about whether minors have a capacity to consent for EAS. Salter’s discussion of adolescent decision-making states: “We haven’t yet agreed on a stable definition of capacity in this population, much less a reliable instrument for measuring capacity” (2017, p. 35).

The law sets an age at which Canadians may make significant decisions, such as voting or purchasing alcohol, and it is appropriate and reasonable to set a minimum age for the decision to end life.

In general, the less weighty the outcome, the more a minor plays a role in the decision. EAS cannot be undone or mitigated, it is intended to kill, and thus it cannot be considered like any other type of medical treatment over which minors may have legal decision-making power.

There is a moral and ethical difference between refusing or withdrawing treatment and EAS. In cases where a minor participates in a decision that results in his or her death, the minor is refusing treatment, not consenting to a lethal injection. The intention to end a life, rather than to alleviate pain, makes euthanasia and assisted suicide fundamentally different than end of life care.

Canadian courts will override a minor’s refusal if the odds of survival are good with treatment.

Advance requests

The EFC opposes allowing EAS by advance request. Competency at the time of EAS is a critical safeguard against involuntary euthanasia.

Advance directives are very complex and difficult to carry out because of the nuances and specifics of complicated medical conditions and interventions (“Evidence - PDAM (42-1) - No. 11 - Parliament of Canada,” 2016).

Predictions about future suffering are speculative. As Franklin noted in an article on dementia and euthanasia: “there is simply no way to know how the disease will affect a person or how the person will feel about their quality of life once the disease has set in” (2014, p. 568).

Advance requests put significant additional responsibility on the physician, who must decide at what point a patient’s life will end. It’s an interpretive role but also a progression in role. The doctor goes beyond carrying out the patient’s request to interpreting the request, possibly in the midst of unforeseen circumstances and complications, and deciding on the timing.

People change their minds. As a study by Emanuel, Fairclough and Emanuel noted, half of the terminally ill patients who had seriously considered EAS for themselves changed their minds (2000).

Q2. Please identify or provide relevant knowledge that your organization would like to have considered by the CCA Expert Panel on MAID as it relates to mature minors, advance requests, and/or where mental illness is the sole underlying medical condition. Please provide web links, references, or attachments.

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