

Submission to:
The Special Joint Committee on Physician Assisted Dying
From:
the Christian Reformed churches in Canada
February, 2016



INTRODUCTION:

We believe that God is the giver and taker of life in all of its beauty and complexity, and we honour the gifts of the contemporary practice of medicine, which sustain both life and human dignity. Medical advances in end of life care create ethical and legal challenges that require careful and wide ranging deliberation towards sound public policy. The need for this deliberation will continue beyond the immediate need to address the Supreme Court of Canada decision *Carter v. Canada* (SCC Carter) in legislation. Given the profound ethical questions surrounding physician assisted death (PAD), it is our hope that any legislative package will emphasize human dignity and compassion at the end of life; robust protection of vulnerable persons; conscience protection of medical practitioners and institutions who object to providing PAD; and provisions for oversight and legislative review.

A PROXIMATE APPROACH:

The Carter case, and others previous and similar to it, was motivated by the profound suffering of terminal disease where quality of life is hindered. This reality of suffering is encountered regularly in the pastoral work of our churches. Indeed the real life experiences of pastoral work have inspired our extensive communal reflections on end of life care. In 2000, the Synod of the Christian Reformed Churches affirmed an approach of “responsibility and community at the end of life” and resolved to:

- Encourage families to discuss end of life issues including advance directives.
- Encourage the allocation of health-care funding for adequate palliative services, home care, and medical support services.
- Encourage government initiatives that will allow medical treatment aimed at pain relief even if that treatment may unintentionally shorten life.
- Encourage government initiatives that will promote life-affirming legislation and oppose legislation that endorses assisted suicide or mercy killing.

Therefore, in the light of SCC Carter we do not favour medical intervention with the deliberate intention of ending life. However, even while voicing our churches’ official objection to PAD, we recognize that the SCC Carter decision requires a legislative response that addresses its articulated Charter concerns. Failure to respond to these concerns in new legislation is likely to result in a legal vacuum with unknown consequences. A lack of legal clarity may well have significant long-term risks for vulnerable people and could intensify the ethical dilemmas faced by medical care providers. Therefore, since PAD is now deemed a legal and Charter imperative it must be carefully regulated, and emphasize the moral agency of the defined competent patient over that of physicians and other people of influence as end of life care decisions are made.

Furthermore, we are concerned that the issues surrounding PAD are of great complexity and require a substantial period of public deliberation. One of the more recent public policy reflections on medical ethics was the subject of a Royal Commission with a 4-year mandate (*Royal Commission on New Reproductive Technologies 1989-1993*). This public reflection on issues related to the beginning of life was challenging and reflected the deep ethical significance of these issues. We expect a meaningful level of public ethical reflection will also be appropriate to end of life issues. The current legislative timeline to respond to SCC Carter is markedly shorter than the time needed for comprehensive public reflection



on key end of life issues. With this in mind, we encourage measures in PAD legislation that mandate a thorough review process to provide for meaningful public deliberation and adaptation of an initial public policy framework for PAD.

The *External Panel on Options for a Legislative Response to Carter v. Canada* found significant (and statistically representative) public support for a national PAD oversight body. Detailed tracking of statistics and the legal and ethical issues of a nascent PAD regime are critical for transparency and public confidence, and will assist in ongoing determinations of efficacy and public good.

ISSUES OF CONCERN:

We present the following issues of concern as matters for the deliberation of this Special Committee and the Government of Canada in the formation of PAD legislation:

1. Involuntary Euthanasia and informed consent

One of our primary concerns in any legal provision for PAD is the prospect of *euthanasia without consent*. In Europe there are occasions in which the physician may legally apply life-ending medication without the consent of the patient. These events of involuntary euthanasia are rare but underscore for us the need for robust measures for informed consent in any PAD regime.

A grounding for informed consent are *advanced directives*. These provide clear expression of a person's wishes concerning end of life care before a time that they are no longer capable of competent decision making. Any legislation concerning PAD should include specific provisions for the respect of advanced directives, as well as public education to encourage their use.

The principal risk we foresee in any PAD regime is the loss of patient autonomy in the event of involuntary euthanasia. This is most certainly a concern for disabled people and other vulnerable communities. A legally defined competent patient is the primary moral agent responsible for a PAD decision. The prohibition of administrators, physicians, and even family members from overriding the decision making agency of the individual patient will therefore be a critical clause for the prevention of involuntary euthanasia. Specific reference to the protection of disabled people and other vulnerable populations is essential in PAD legislation.

2. Medical care providers/Institutions conscience protection

Given the diversity of opinion on PAD and end of life ethics, physicians and other medical care providers, including institutions, need meaningful conscience protection in any PAD regime. Canada's public health care system puts medical care providers in clear positions of public service that require respect of, and provision for, the diversity of patients' perspectives on PAD. Care providers with ethical objections to PAD must not be compelled to provide PAD services. However, conscience bound care providers must not exercise their power in the medical system in a way that restricts the moral agency of a patient to seek PAD services from another practitioner.

Physicians' conscience conflicts could be minimized by establishing a specific and opt-in training certification for physicians providing PAD. No other practitioners should be required to provide PAD services.

3. Palliation and community care:

Out of an abundance of compassion, we place a high priority on enhancing palliative care and community supports for people at the end of life. The honourable heritage of Canadian public health

care displays a profound respect for life, health, and human dignity. We hope that this heritage will be reflected in contemporary developments in end of life care. And particularly, in light of House of Commons motion M-456 (2014), we hope that Canada and the provinces develop a robust national palliative care strategy in collaboration with the full range community care providers (for profit, faith-based, ethnic etc). The urgent SCC-inspired focus on PAD must not supplant this deeply important conversation. Public policy dialogue and development on compassion and human dignity at the end of life must not be restricted to PAD. It is our conviction that since PAD is deemed legally necessary, it should be exceedingly rare. An integrated palliative care strategy that provides appropriate medical support and enhances community engagement can provide patients with a range of options at the end of life. People who suffer at the end of life must be provided all possible provisions for dignity and comfort: excellent palliative care and pain management (even that which may hasten death); and the social and spiritual support that is provided in a context of community. We note that the *External Panel* found significant public support for the implementation of national strategies for palliative care, home care, and disability support. Each of these measures, properly developed and administered, can provide compassion and dignity for people throughout and at the end of life. This is a critical area of public policy formation in a context of an aging population and the deepening complexity of ethics in medical care.

RECOMMENDATIONS

Given the speed of care advancements and the ethical complexities of compassion and human dignity at the end of life, our churches have not had opportunity for a fulsome discussion on the issues addressed in SCC Carter. Ethical reflection on controversial issues takes time and must be sought out even under the constraints of the SCC deadline. However, given a commitment to constructive contributions to this important public dialogue we offer the following initial recommendations:

1. Review and oversight:

- a) That any federal PAD legislation include a formal 3 year review. The review should mandate comprehensive national consultations with stakeholders on the efficacy, public good, and ethical challenges of any initial federal legislation as part of an expected updating and amendment process.
- b) That the committee take note of the *External Panel's* finding of public support for significant national oversight of the practice of PAD and implement an appropriate regime.

2. Respecting moral agency:

- a) That a legally defined competent patient is the moral agent responsible for any decisions with respect to end of life care. Therefore, legislative measures to minimize coercion and undue influence, and to prevent involuntary euthanasia, are critical. Special attention to the protection of disabled people and other vulnerable populations, and particularly to their moral agency, is essential.
- b) That any PAD regime use *advanced directives* as the preferred expression of a patient's wishes. And further, that public education on advanced directives be a part of any legislative package for PAD.

3. Medical care providers' conscience protection:

That conscience bound medical providers and institutions not be required to provide PAD services. In this respect we commend to you the Canadian Medical Association's *Principles-based Recommendations for a Canadian Approach to Assisted Dying*, and in particular their:

- *Foundational Principle 3* - respect for physician values;



- *Recommendation 3* - PAD services provided by specifically trained physicians. This is an opt-in provision that allows conscientious objectors to opt-out.
- *Recommendation 5* - protection for physicians and institutions with moral objections to PAD that also respects the moral agency of patients seeking PAD.

4. That the Government of Canada, as part of any legislative package on PAD, engage in high priority consultations with provinces and a comprehensive range of stakeholders for the implementation of House of Commons Motion M-456 and the development of a national palliative care strategy.

Respectfully submitted,

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