

The Anglican Church of Canada



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

**The Anglican Church of Canada**

**3 February 2016**

### **Background**

The Anglican Church of Canada includes approximately 700,000 people across Canada, including a strong indigenous membership, along with people who come from every continent. While we were once a church of dominantly anglo-celtic ethnicity, we are now a multi-ethnic church with a face that looks a lot like the face of Canada. We are also a church of diverse perspectives on almost any issue you can say. We are rooted, though, in a shared compassion and a shared conviction of the worth and dignity of human persons, a compassion and conviction we share with many Canadians.

We have chosen here to frame our submission based on questions that arise from extensive Anglican pastoral practice and reflected upon experience, along with insights from our moral and theological tradition. Regardless of their position with respect to the Supreme Court's Decision in the Carter Case, Anglicans across the country are deeply involved in thinking about and discussing the complexity of its implications. Our church leaders have been providing leadership in public forum discussions and in consultations with regulatory bodies.

We trust that the questions raised here will contribute to your deliberations as you work out a legislative framework following upon the decision of the Supreme Court in the Carter case. <sup>1</sup>We recognize that Anglicans across the country hold, in differently nuanced ways, views on the rightness or wrongness of the Supreme Court decision. We also, though, share

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<sup>1</sup> What follows is not a formal *statement* of The Anglican Church of Canada either for or against physician assisted suicide. Such a statement would require a resolution of our highest decision making body, the General Synod, and would presume a will to action by that body on a matter that may well fall within the category shared by other issues held by us to reside within the sphere of conscience.

fundamental values, points of doctrine, and ways of moral discernment. At root, these values are not incompatible with those shared more widely in Canadian society.

Ours is a contribution that comes from the concrete experience of accompaniment with the sick and dying, their families and communities. It is shaped by our commitments to social, economic and racial justice, the dignity of the human person, and the practices of love, compassion, and care. We are learning continually what it is to walk in committed partnership with those who are different from our majority population, and know what it is to listen well. When we listen, on this matter, we hear very good questions.

The Anglican Church of Canada is not new to the consideration of tough ethical issues regarding death and dying. In the mid-1970s, a report was commissioned to offer guidance on end of life care. When issues relating to euthanasia rose to prominence in public discussion in the 1990s, our Church carefully conducted research and engaged public discussions. The result was *Care in Dying* (1998), a resource still much in use today. It has helped to educate our constituency, for example, on the distinctions between pain relief that has a secondary effect of hastening death, and passive and active euthanasia. Though not a statement of policy, it has served us well in raising issues of concern and questions for further deliberation.<sup>2</sup>

At present we have a dedicated task force working specifically to address the matter of physician assisted dying. Its members include health care and legal professionals, (with specialists in medical ethics, palliative care, health care law, family medicine, and nursing) pastors, ethicists and spiritual care providers. It is as such deeply inter-disciplinary, and involves highly-placed professionals.

Within our church, lay leaders and lay pastoral visitors, parish nurses, deacons, parish priests, and chaplains have long and deep experience in accompanying the sick and dying, along with their families and primary communities. We know what it is to walk with people who are in pain and suffering, and through difficult end of life decisions.

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<sup>2</sup> "The General Synod in 1975... established a task force on human life whose work resulted in the report, *Dying: Considerations Concerning the Passage from Life to Death*. This report did not give extended attention to issues of euthanasia and assisted suicide. In 1990, the Doctrine and Worship Committee was asked to formulate a theological statement on euthanasia. A draft statement was produced by a working group in 1995... (but was put on hold) ...In the fall of 1996, the Faith, Worship and Ministry Committee were approached by the Canadian Council of Churches... (who) asked whether a draft statement prepared by their Faith and Order Committee...was consonant with the policy of the Anglican Church of Canada. (We)...were unable to confirm that the statement was consonant with the church's policy because, at this time, we have no policy. ...Further, (our)... conversation suggested that, although there were clear differences of perspective, there were some common concerns. While they recognized the need to think carefully about the status of any statement, the committee came to believe a statement whose primary intention was pastoral would be valuable. They believed that the aim of the statement should not be primarily to seek to dictate policy to lawmakers, but to raise issues which might be of concern to many Anglicans and other people of good will on both sides of the debate." From *Care in Dying*, 1998. The present stage of work in 2016 takes the same approach: raising issues and questions.

Spiritual care providers are often intimately involved within the wider framework of the health care team and the family of the patient. Though spiritual care involves prayer and sacrament, it is even more about sharing a journey, both with the patient and with the family, in which deep listening fosters reflective openness - emotionally, morally, spiritually and intellectually. Spiritual care is always about inviting and attending to the patient's own narrative and reflections, and always carries with it an element of conversational moral and ethical discernment. In all of this, we are called to walk together, listening and talking, without being prescriptive, but enabling patients and families to make the best decisions they can within the context in which they are living, and within the best possible support systems.

The Anglican Church of Canada Task Force on Physician Assisted Death has just completed a resource to support those who provide care and accompany the dying.<sup>3</sup> The introductory chapter is headed with a verse from the Hebrew Scriptures (The Old Testament) that reads:

***But seek the welfare of the city where I have sent you into exile, and pray to the Lord on its behalf, for in its welfare you will find your welfare (Jeremiah 29:7)***

This part of our Jewish and Christian story reminds us of several things, with respect not only to this particular issue in health care. We are part of 'the city', a wider community, nation or country in which not everyone is like us, nor should they be, nor do we expect that the wider community outside (in our case) the Anglican Church of Canada to have the same faith perspective, or any faith perspective, to bring in to moral discernment, debate or the creation of legislation.

And, in that context of 'the city,' we have a duty to care about, to pray for, to live in harmony with, and to act with respect to all others on the basis of their inherent human dignity and worth. This extends to the ways in which Anglicans have consistently offered spiritual care to any who call upon us, and those whom we encounter in daily life (of any faith tradition or no faith tradition). Our understanding of the duty to care for all extends, truly, to all: persons of different or no faith tradition, and those who choose physician assisted death, and those who do not choose this way.

These experiences have nurtured in Anglican pastoral sensitivities a lived wisdom that has become quite good at asking questions, particularly when faced with what seem to be binary positions or options. One of the things that we therefore offer, in seeking "the welfare of the city" is a stance that looks squarely at these options, pays attention to wider contexts of persons-in-community, cultures, power and privilege issues and considerations of compassion and justice all around, and says "it's not that easy." From there, we begin to raise important questions.

In light of the Supreme Court decision, the following are questions and concerns that we offer with the request that the Joint Committee receive with a commitment to engage.

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<sup>3</sup> Expected to be released by the end of February 2016.

## **1. Dignity, Personhood, and Community**

At the foundation of Christian faith is the assertion that all human beings are created by God, in the image and likeness of God. It is on the basis of our very creation that we are motivated to uphold the dignity and worth of every human life. At the roots of our faith is the assertion that human persons, being in the image and likeness of God, are the bearers of an inalienable dignity that calls us to treat each person not merely with respect for their personhood, but with love, care, and compassion.

From these assertions follow the high value placed on personal conscience. It is not in juxtaposition but in harmony that we also say that persons do not exist apart from relationships. The questions are not about individual versus community based decision making (either-or), but rather about the person within his or her relationships (both-and). Personal conscience must be honoured, conscience shaped in the context of non-coercive, healthy, and just relationships towards sound decision making. The right to individual self determination and personal freedom and choice, and the right not to be coerced, are themselves rights shaped in concrete relationships.

Noting that the Supreme Court decision in Carter presumes the person to be a fully autonomous being, we raise here several questions.

Many cultures and faith traditions within the Canadian context are of the view, shaped by lived experience, that every person is part of a community, wherein they participate in receiving and in shaping values and responsibilities. Individual values and decisions are shaped by relationships, and individual choices and concomitant actions have an effect on the community. Personal conscience must be followed; and all personal conscience shaped within the complexity of real relationships.

**How might the legislative framework pay attention to key relationships around the patient, when looking at the causative elements in the patient's decision making in order to determine the freedom of a decision?**

It is said by some that from North Atlantic/Western culture has emerged a sense of selfhood and individual rights that is simply a matter of inevitable positive development. However, assertions of this sort are continually tested and found wanting, both in everyday interdependence of persons in communities and families, and at times of crisis. The Anglican Church of Canada knows deeply, and in ways that challenge our own structures and priorities and values, how colonialism has devastated the Indigenous peoples and the cultures of this land, enforcing more individualistic systems and destroying communal cultural ways.

**What do the Indigenous peoples of this Land, and others whose lives and decision making processes are more shaped by the high value placed on community, have to**

**teach us? What will a legislative framework look like after having listened and learned to these experiences?**

To assert that each human being has inherent dignity is to talk about worth and value in the essence of the person. We wonder how it has become that the notion of dignity has come to be equated with the power to have authorship over one's own life. In this shift, dignity is construed on the basis of certain qualities and capacities - an ideological equation that implies that those without full power of self-determination and autonomy over their own lives (bodies and minds) have lesser dignity than others. Is this not a dangerous path, and contradictory to advances that have been made with respect to care for vulnerable populations and those who have had their self-determination stripped from them?

**When referring to dignity of the person or of the choice, what are the factors that determine dignity? Does someone without the capacity to opt for a choice not to ask for physician assisted death not have sufficient dignity? How will you treat the notion of dignity within the legislative framework without narrowing to a definition that excludes large segments of the population from being considered to possess dignity?**

Anglican tradition and practice uphold some core principles, namely that moral discernment be:

- Compassionate: rooted in love and empathy;
- Concrete: more concerned with faithfulness to the gospel and character of Jesus, than with abstract and generalized rules or principles;
- Communal: taking place within community;
- Conscientious: respecting and calling forth the conscience of a person within the reality that they face (conscience must be followed)
- Critical: not content with the simplistic totalizing responses of other sides.

**Will a framework for legislation foster a context in which the conversations called for by these principles will be encouraged, or be truncated?**

Our Canadian society reflects the conflict between our commitment to care for the vulnerable, and the pressures of a more competitive individualism. The health care system is perhaps the place wherein these conflicts are enacted the most, and where - in situations of extreme financial pressure - duty to care is vulnerable to an interpretation that defaults to a less expensive set of options.

**How can a legislative framework ensure that appropriate care does not suffer from economic restriction, either real or ideological?**

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## **2. Nation to Nation Relationship**

We rejoice in the commitments, made by our Federal Government under Prime Minister Justin Trudeau, to new and just relationship between the Federal Government and First Nations, Inuit, and Métis communities. These are being framed as “Nation to Nation” relationships. We have learned so much, and we have so much more to learn from conversation with First Peoples. The conversation starts from the stance of newcomer peoples and dominant cultures and powers first *listening*.

On the basis of longstanding commitments and actions towards healing, reconciliation, and justice in right relationships with the First Peoples, the Anglican Church of Canada is conscious of when and where Indigenous voices and perspectives are present and when and where they are not.

**What assurance can the Joint Committee provide that First Nations, Inuit, and Métis leaders, and those who provide health care in those communities, are being consulted fully, Nation to Nation?**

**How would a legislative framework include values and perspectives from Indigenous peoples not as a special case, but integrated in a fully Canadian piece of legislation?**

Our Task Force invited submissions from Anglicans across the country about the matter of Physician Assisted Dying. Amongst others, we heard from health care workers in northern and Indigenous communities wherein, as is commonly known, the rates of suicide especially amongst young people is highly disproportionate to those in the rest of the population. This extends beyond the north to Indigenous peoples living in urban centres. Those who wrote to us expressed bafflement that there could be decisive and swift action on provision of physician assisted suicide when a) the crisis in suicides has not been addressed in ways that have made a difference in their communities, and b) there is inadequate health care and social service provision in so many poorer parts of our nation – for primary, specialist, psychiatric and palliative care.

Our church has undertaken a major initiative in suicide prevention. For many years our leaders have been on public record urging change in the conditions of poverty, intergenerational healing from Residential Schools, and other major social and economic illnesses at the root of the crisis of suicide.

Amongst the *Calls to Action* in the *Final Report of the Truth and Reconciliation Commission* is to be found a large section on health care (Numbers 19-24 especially) and justice (Numbers 36-41). It is clear that these priority areas demand immediate action. Issues of the suicide of teenagers and the requests for physician assisted suicide are not unrelated when we look at them from the perspective of these vulnerable populations.

**What related initiatives will be recommended by the Special Joint Committee for equally immediate and decisive action?**

## **How might the legislative framework under construction at present contribute towards a wider, coherent expression of values in health care for Canadian society?**

We acknowledge the difficulty of speaking into the context of legislation framing around physician assisted death – on such a very tight timeline - when so many of our Indigenous Anglican members, and all Indigenous Peoples with whom we are walking in solidarity and partnership, have yet to see significant action on the health care aspects of the TRC.

### **3. Contexts of Care and Access: Grounds for Questions about Coercion and Decision**

We note that the Supreme Court Decision in the Carter case uses the word “care” as synonymous with “treatment.” Care is about more than active treatment, provision of medication or therapies. It is about the wider context of care for the whole person, whose whole being is involved in any decision making process. This extends to spiritual care, psychological care, economic care, physical care that is much wider than medical treatment, support, and social welfare. Views have been expressed that provision of spiritual care is an automatic form of coercion against a free and clear decision to request physician assisted death. This bias does not reflect the realities of many professional spiritual care providers. Furthermore, the provision of this form of care to someone who has made the choice to be assisted into death can be one of the most critically important ways of supporting the patient and family in the process of waiting, in dying, and in the immediate time of grieving in which complex emotions and thoughts will need careful tending.

#### **Will the framework for legislation make provision for and encourage access to spiritual care?**

Some ask: how to ensure universal access to physician assisted death? The very deep and wide gaps in provision of universal access to medical care broadly speaking, both primary and specialist, pain relief and particular treatments, let alone palliation and hospice care (about which we will speak more fully below) raise critical questions about the free nature of a decision. If there are no other options available – whether high quality active treatment of disease or good palliative care, can a choice be considered ‘free?’ Are there not contexts wherein the lack of options itself creates a context of coercion? There is a difference between having a right, and giving access to structures respecting full dignity in which to exercise that right.

#### **How can the legislative context itself provide a structure that supports healthy decision making, including assurance of quality palliative and hospice care within the issue of universality of access?**

This Canadian Supreme Court decision, unlike those of other countries, does not require the patient to be terminally ill, only a “competent adult” who is “grievously and irremediably ill.” Several questions come into sharp focus around this particular clause:

- The definition of an ‘adult’ is not provided. **What if a child is ‘grievously and irremediably ill’? How can legislation aid in measuring maturity and competence, and deal with the complex matter of coercion of a young person?**
- Those in perpetual, excruciating pain are in a different world from those who are not. **How might the legislative framework provide guides to evaluating a patient whose pain, or pain relieving medication, may decrease mental clarity?**
- If suicidal ideation in someone who is mentally ill is treated as a symptom of the disease, how do you determine the difference between the causality of decisions, especially when in many cases the symptom of suicidal ideation is a first presenting public symptom of mental illness? **How is mental health – as a ground of competence and freedom from coercion – to be assessed? What are the implications for mental health care?**
- Coercion can take many forms: finances, a sense of family responsibility, putting the elderly into institutions, lack of knowledge, societal pressures, lack of access to medical treatment and pain management or the options of palliation. **Will the legislative framework identify possible forms and signs of coercion and how such will be assessed?**

#### **4.Palliative Care and Hospice**

*You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die, peacefully, but also to live until you die*

Dame Cicely Saunder (1918-2005), founder of the Palliative Care and Hospice movement.

Palliative care and physician assisted suicide are not complete opposites. They have a complicated relationship. Palliation is a form of assisting a person in their dying. The Canadian Association of Palliative Care Physicians (CAPCP) has reported to this Special Joint Committee, palliative care is only accessible by approximately 30% of Canadian citizens.

Anglican spiritual care providers – often serving as multifaith chaplains – have a great deal of experience in palliative and hospice care. One of our Task Force members served to found spiritual care at Casey House in Toronto and accompanied patients with AIDS for close to two decades.

Where the provision is of high-quality care, the journey of dying is accompanied by care that extends well beyond that of medical therapy. Many of our leadership, it is safe to say, would support the initiatives of the CAPCP in their call for a National Secretariat in Palliative Care, as reported in their brief of January 27, 2016.

While it may not be something within the direct and narrow remit of those drafting legislation for physician assisted dying, **how might this Special Joint Committee raise**



**into prominence the critical need for more, and better, palliative care as central to the priorities and values of our health care system?**

### **In Conclusion**

Our reflections here, and the questions raised, are not an objection to the decision of the Supreme Court – that decision has been made by the court, and we welcome the opportunity to contribute to a carefully crafted legislative framework that serves the inherent dignity of each human being within their primary community of support. We care for the most vulnerable in our society, and walk with them. We are committed upholding the importance of personal conscience, and wish to find ways to ensure that such is formed without coercion. We are concerned about limited access to high quality medical care, including palliative and mental health care, especially in northern and Indigenous communities, with whom we walk in partnership. And we will continue to equip and support our pastors in their compassionate and wise care of the dying.

### **Summary of Questions:**

1. How might the legislative framework pay attention to key relationships around the patient, when looking at the causative elements in the patient's decision making in order to determine the freedom of a decision?
2. What do the Indigenous peoples of this Land, and others whose lives and decision making processes are more shaped by the high value placed on community, have to teach us? What will a legislative framework look like after having listened and learned to these experiences?
3. When referring to dignity of the person or of the choice, what are the factors that determine dignity? Does someone without the capacity to opt for a choice not to ask for physician assisted suicide not have sufficient dignity? How will you treat the notion of dignity within the legislative framework without narrowing to a definition that excludes large segments of the population from being considered to possess dignity?
4. Will a framework for legislation foster a context in which the conversations called for by these principles will be encouraged, or be truncated?
5. How can a legislative framework ensure that appropriate care does not suffer from economic restriction, either real or ideological?
6. What assurance can the Joint Committee provide that First Nations, Inuit, and Metis leaders, and those who provide health care in those communities, are being consulted fully, Nation to Nation?
7. How would a legislative framework include values and perspectives from Indigenous peoples not as a special case, but integrated in a fully Canadian piece of legislation?

8. What related initiatives will be recommended by the Special Joint Committee for equally immediate and decisive action?
9. How might the legislative framework under construction at present contribute towards a wider, coherent expression of values in health care for Canadian society?
10. Will the framework for legislation make provision for and encourage access to spiritual care?
11. How can the legislative context itself provide a structure that supports healthy decision making, including assurance of quality palliative and hospice care within the issue of universality of access?
12. The definition of an 'adult' is not provided. What if a child is 'grievously and irremediably ill'? How can legislation aid in measuring maturity and competence, and deal with the complex matter of coercion of a young person?
13. Those in perpetual, excruciating pain are in a different world from those who are not. How might the legislative framework provide guides to evaluating a patient whose pain, or pain relieving medication, may decrease mental clarity?
14. If suicidal ideation in someone who is mentally ill is treated as a symptom of the disease, how do you determine the difference between the causality of decisions, especially when in many cases the symptom of suicidal ideation is a first presenting public symptom of mental illness? How is mental health – as a ground of competence and freedom from coercion – to be assessed? What are the implications for mental health care?
15. Coercion can take many forms: finances, a sense of family responsibility, putting the elderly into institutions, lack of knowledge, societal pressures, lack of access to medical treatment and pain management or the options of palliation. Will the legislative framework identify possible forms and signs of coercion and how such will be assessed?
16. How might this Special Joint Committee raise into prominence the critical need for more, and better, palliative care as central to the priorities and values of our health care system?

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