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To: The Special Joint Committee on Physician-Assisted Dying

Attention: Cynara Corbin
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House of Commons

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The Senate of Canada

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From: The Right Rev. Jordan Cantwell
Moderator
The United Church of Canada

The United Church of Canada is currently developing a statement on physician-assisted dying, a process that will require hearing from different voices within our church. It will be some time before we have an official position on physician-assisted dying, nor are we confident of a consensus position within our church around these issues. Given the time frame of the Parliamentary Committee's work, I am writing as Moderator to offer these thoughts for your consideration. Our church has a long tradition of affirming relational ethics and the capacity of individuals to struggle with difficult life decisions. While perspectives and opinions on the question of physician-assisted death and voluntary euthanasia vary widely within our Church, I would like to offer the following points for the Committee to consider as you prepare your report:

Access to quality palliative care and increased capacity for pain management must accompany any movement to legalize physician-assisted dying. This must involve a greater appreciation for multiple approaches to managing pain and implementation of best practices in palliative care in every jurisdiction. We know that ongoing physical pain can, and often does, have a huge impact on one's mental and spiritual well-being. One's capacities for coping with the physical, mental, and spiritual suffering associated with illness are impacted by the kinds and extent of supports available to individuals and their families/care givers. The choice to end one's life in order to alleviate unbearable pain and suffering should always be seen as a last resort.

Christian tradition holds life to be sacred but not absolute, always to be valued and protected, but also to be considered in the context of the quality of life of the individual and of the community. The Very Rev. Gary Paterson, a former Moderator of the United Church expressed it this way:



“For Christians, life is a sacred gift from God and needs to be valued and protected. But we also know that both life and death are part of the whole created order. Life itself isn’t absolute. Nor certainly is death. To speak of the sanctity of life is to affirm God’s desire for abundance of life for all of creation. God is love, and the Christian affirmation is that God’s love is the only absolute. ‘In life, in death, in life beyond death, God is with us’ says our creed.

So the United Church’s theological tradition is not to suggest that believing in the sanctity of life means that any attempt to end life must be prevented. Instead, what we are called to do is first listen to the struggles of those who are facing hard decisions and to make sure that they are not alone in those decisions, and second, to trust people with difficult choices about their own lives.”

Emphasis should be on the moral agency of an individual to make this difficult decision on their own behalf, in consultation with their loved ones and their doctor. What constitutes a “dignified death” is subjective and can only be determined by the individual. However, people are social beings who live, function, and find meaning within relationships. It is important that people facing end of life decision-making have the support and accompaniment of others whom they can trust and who have their best interests at heart. Where individuals lack family or friends who can accompany them in this decision making process, efforts should be made to provide supportive accompaniment through social workers, chaplains, elders, or others whom the individual requests.

The question of individual consent and initiative must be paramount. This speaks first of all to the importance of having adequate measures in place for determining the competency of an individual to make ultimate life and death decisions on their own behalf. It necessitates that all possible precautions be put in place to protect vulnerable persons from implicit or explicit pressure or coercion in their decision-making. We can learn from the example of those jurisdictions that include numerous steps of assessment designed to protect against coercion.

[Particular concern has been expressed by associations of persons with disabilities regarding assisted dying arguments. They note that almost all the physical conditions expressed as underlying reasons for seeking physician-assisted dying are also related to disabilities: loss of personal freedom, ability, independence, and control; dependency on others and physical suffering. The significant fear is that societal approval of physician-assisted dying will lead to a devaluing of the lives of persons with disabilities and subtle or not so subtle encouragements to end one’s life to be less of a burden to family and society. Similar fears are also expressed for the elderly, with the added potential for coercion to preserve inheritances.

These concerns are significant and need to be addressed. However, it is also important to reject paternalistic attitudes toward persons with disabilities who have the right and capacity to make decisions about their own lives.]

It also raises questions about when consent can be given – how close to the time of the action that ends life must the individual explicitly give their consent to it?

People often cannot accurately predict how they will feel or respond in a new situation until they are actually in it. It is sometimes in the midst of great trials that we discover reserves of courage and strength we did not know we had. Similarly, it may be that the condition of profound vulnerability opens us to an experience of grace we could not have foreseen. For this reason, consent should be given as close as possible to the action that will end life. Ideally, the final initiative should be the individual's. This ensures that doctors are always advisers in this respect, not decision makers. (*See below for further reflection on this point.*)

In making these decisions, the wellness or wholeness of the individual—spirit, mind, and body—must be kept in the forefront. The First Nations understanding of the continuity of all of creation expressed in the affirmation “All My Relations” reminds us that we are part of the natural order of life, which includes death. Yet we recognize that humanity carries a special responsibility or stewardship for creation. This is not based in domination, but rather understood in terms of “mending.” In some ways, we are all like physicians, whose first calling is to do no harm; and beyond that, to care for the well-being of our world and each other.

The emphasis on physician-assisted dying being a decision between an individual and their doctor implies that the doctor must also be allowed the right not to participate if they believe it inappropriate to do so. Support for physician-assisted dying must take into account the difficulties faced by medical staff both in contributing to the ending of an individual's life, and in the emotional implications that might result. In August 2014, the head of the Canadian Medical Association, Dr. Chris Simpson, commented that there are enough doctors in Canada willing to perform doctor-hastened death if the law allowed. But doctors first need safeguards to protect the vulnerable and a strategy to urgently shore up palliative care “so that this is not seen as a first, or second, or even a third choice, but a choice that's appropriate for people after all other reasonable options are exhausted.”

Where an individual who qualifies for physician-assisted death under the new legislation requests their doctor's assistance to end their life, but the doctor has objections to participating, the doctor ought to be obliged to refer the individual to another doctor. This is consistent with other legislation, such as the abortion laws, which allow freedom of conscience for medical professionals without jeopardizing equal access to medical care for individuals.

Further reflection on individual initiative and consent:

Drawing a legal distinction between physician-assisted dying where the individual takes the final action to end their own life and voluntary euthanasia has the clear advantage of ensuring consent. This direction raises particular concerns for individuals suffering from progressive diseases such as ALS, which was the illness Gloria Taylor faced. Justice Smith, in her ruling, specifically noted the inequality before the law faced by individuals in such situations given that suicide itself is no longer a crime. While those who face other forms of illness have the knowledge that they will maintain capacity to take personal action, ALS sufferers and others in similar situations must deal with the reality that there will come a time when they can no longer take personal action. The dilemma they face therefore is whether to take action before this time arrives. In other words, they are forced into a situation where, if they choose to end their life, they must do so prematurely.

Legislation for physician-assisted dying might, however, provide for careful assessment of such situations and allow, at a time of choosing of the individual, for the insertion of an intravenous drip and the provision of a mechanical aid that could begin the insertion of lethal medication into the drip on the action of the individual (perhaps controlled by a breath tube.) This would preserve the importance of the final step of individual action. This option would require increased oversight, but it is not beyond resolution.

A similar but more difficult situation is presented by sufferers of dementia and Alzheimer's. Here the progressive loss of reasoning capacity presents a profoundly difficult conundrum to individuals who know that they are losing their ability to make any decisions at all. Justice Smith's argument concerning the inequality faced by such individuals is even more present. However, to take an additional step of allowing for pre-planned euthanasia in such cases after the person has lost reasoning capacity and can no longer initiate the act themselves (regardless of the extent of the advanced directives) raises profound questions of personal responsibility for the action. To imagine a society where, as a matter of course, individuals who had reached a certain stage of dementia would be euthanized is inconceivable, regardless of whether the action is supported by end of life directions. It would still of necessity involve someone other than the individual making the final determination. It also could potentially lead to unconscious or more blatant societal coercion that such directives were expected. Concern for vulnerable people, as well as other concerns, have led many jurisdictions that support physician-assisted dying to reject the next step of pre-planned euthanasia. The difficult reality of dementia-related illnesses would best be addressed through the development of better care options and facilities.