



NGO in Special Consultative Status with the Economic  
and Social Council of the United Nations

**C-7 AN ACT TO AMEND THE CRIMINAL CODE (MEDICAL ASSISTANCE IN DYING)**

**Presented to:**

**House of Commons  
Standing committee on justice and human rights**

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## Introduction

REAL Women of Canada is a national women's organization, federally incorporated in 1983. We support the equality of women and the family consisting of mother, father and children. We believe the family is the foundation of society.

We are concerned about all members of the family, including the aged, the disabled and all other vulnerable individuals such as the depressed and the mentally ill. This concern has given rise to our apprehensions about the policy of physician-assisted suicide.

The hasty process by which an expansion of physician-assisted suicide is to be part of our legal structure is deeply troubling. The law on assisted suicide has changed from it being illegal under the *Criminal Code*, to becoming wide open to interpretation and implementation, resulting in a complete change to the entire fabric of Canadian society and our long-held respect for the dignity and value of each human life.

Those who support assisted suicide argue that they do so out of sympathy and compassion for the sick and dying. There is nonetheless, underlying this position, a belief that lives may be exterminated if those lives are no longer deemed worth living.

The Supreme Court of Canada had foolishly and naively stated that "properly designed and administered safeguards would protect ... vulnerable people from abuse and error." This false belief has led to 13,946 deaths since 2016 by assisted suicide, according to Health Canada's first annual report, released in July 2020. However, new data from the Ontario Office of the Chief Coroner in October 2020 indicates that number has increased to at least 15,833 deaths. Canada's rate of death by euthanasia has increased more rapidly than in other permissive countries, with annual numbers that are double the deaths from motor vehicle accidents.

Three Canadian palliative care physicians, Doctors Leonie Herx, Margaret Cottle, and John Scott, have published *The "Normalization" of Euthanasia in Canada: the Cautionary Tale Continues* in the World Medical Journal, April 2020. These physicians are struggling to maintain respect for the dignity of human life in face of the widening maelstrom of euthanasia. They have pointed out that the major flaws in the legislation are:

1. Ambiguous eligibility criteria for death
2. A lack of adequate and appropriate safeguards
3. The erosion of conscience protection for healthcare professionals
4. The failure of adequate oversight, review and prosecution of non-compliance with the euthanasia legislation

Their article reports on the terrible consequences of this legislation, deliberately and misleadingly called "Medical Assistance in Dying" (MAID). Their article, which has been endorsed by 142 other Canadian physicians, serves as a warning to other countries, which may be considering similar legislation. The article undercuts the popular portrayal of euthanasia in Canada, which is presented only in positive terms. Instead, these physicians provide evidence to demonstrate that there are tragic, negative and

dangerous consequences to the euthanasia legislation, which is a radical shift in medicine, and especially in palliative care medicine.

The authors also point out that, in four years, Canada has moved from approving euthanasia for so-called exceptional cases, to euthanasia being used as a normal, almost routine, option for death, even before the implementation of C-7. This has been due in part to Canadian judges reinterpreting the law to widen it by inserting their own personal interpretation of the issues. Also, a less restrictive interpretation of eligibility criteria is being used by the providers of euthanasia, who do not face intervention from the courts. Euthanasia providers have referred to this expansion as merely “a maturing of the understanding of what we’re doing”. This has led euthanasia providers to approve cases they would not have previously approved due to earlier fears of criminal prosecution. In short, although reports of violations of the *Criminal Code* and of regulatory body regulations have been documented, no charges have been laid in Canada. C-7 does not address this dangerous situation but will likely exacerbate it.

### **Include Palliative Care in the Canada Health Act as Equal to MAID**

MAID legislation has been positioned as a “healthcare right” under the *Canada Health Act*, so that it is publicly funded, and accessible to all Canadians. However, palliative care has not been positioned as a healthcare right under the *Canada Health Act*, publicly funded and accessible to all. Fewer than 30% of Canadians have access to palliative care and are thus denied access to such care, despite the fact that 98% of those dying in Canada do so naturally, not by assisted suicide. It is paramount that palliative care services in Canada operate independently from assisted suicide services and that palliative care be included in the *Canada Health Act* so that dying patients will have access to publicly-funded and accessible palliative care services as their right at the end of their lives.

### **Palliative Care Undermined by Assisted Suicide Legislation**

During the debates on legalizing assisted suicide, it was argued that access to palliative care would be a “safeguard” against euthanasia for vulnerable individuals. In reality, this has no meaning when there is little access to palliative care as an alternative. Euthanasia is significantly cheaper than rigorous, traditional palliative care, and the financial savings of euthanasia for the healthcare system have already been published in medical journals. With an aging demographic and diminishing fiscal resources, the option to save money in this way may become increasingly acceptable to healthcare decision makers.

### **Confusion About Euthanasia with Palliative Care**

A further problem in Canada is that supporters of euthanasia, such as the Dying With Dignity organization, are deliberately confusing the language of end of life to promote the concept that palliative care also includes assisted suicide. Palliative care would never intentionally hasten death. Also, Dying With Dignity, among others, such as the B.C. government and physicians supporting euthanasia, are pressuring palliative care providers to incorporate euthanasia within the scope of practise. This has occurred with

the ten-bed palliative care hospice in Ladner, B.C., operated by the Delta Hospice Society and in North Bay, Ontario, where physicians involved with assisted suicide attempted to pressure a palliative care hospice to open beds for their use. They argue that euthanasia should be “one of the many items in the palliative care basket”. It is not.

### **Palliative Care NOT Equally Funded**

Since euthanasia has been designated a health care “right”, palliative care must also be designated a right as a matter of equality. Dying patients should have equal access to publicly funded palliative care if assisted suicide is given this privilege.

The availability of euthanasia has had, in another way, a profound effect on palliative care. When a patient states, “I just want this to be over”, there is now a knee-jerk reaction to consult the euthanasia team as a first response and neglect what palliative care has to offer. It has always been a standard of care, however, to engage a patient in serious dialogue or try to understand the nature of their suffering and grief in order to determine what supports might be helpful. That is, an expression of distress needs to be explored and supported in order to help a person and their loved ones to focus on their living, even while dying, and to provide support to people on their journey so they do not feel abandoned or alone. The ready availability of euthanasia prevents this from happening.

### **Palliative Care Today**

Palliative care today, is publicly funded only in hospitals, not by way of home care or otherwise where it would be more effective and affordable. The astonishingly low figure of the availability of palliative care is not due to the fact that the issue has been ignored in Canada. Senate studies on palliative care have been undertaken in 1995, 2000, 2005 and 2010. Perhaps the most definitive study on palliative care was carried out in 2011 by the Parliamentary Committee on Palliative and Compassionate Care. Close to 60 MPs and former MPs from all parties supported this Committee’s work. Many individuals and organizations and groups provided input into it. In November 2011, the Committee published its superb Report called: *Not to be Forgotten: Care of Vulnerable Canadians*. No action has been taken on this report, which includes the recommendation that a National Palliative Secretariat be established. Consequently, despite extensive research, no federal scheme for palliative care in Canada has either been advanced or implemented.

How can we then have a policy of assisted suicide which requires informed consent, when the patient has not been offered a reasonable alternative by way of palliative care? The tragedy is that patients will be killed under assisted suicide simply because he/she lacks equal access to palliative care which would have alleviated their concerns and fears about death. Access to proper, fully adequate pain management provided by palliative care is a fundamental human right. Why then is society allowing the patient to be killed, instead of giving them the offer of this compassionate care and rights?

## **No Real Safeguards**

Another important point the authors of "*Normalization*" make is that the supposed safeguards written into Canada's legislation are illusionary. The failure of safeguards preventing unnecessary assisted suicide in any country was confirmed in an article recently published in the Dutch Medical Association Journal by Dr. Bert Keizer. (The Netherlands legalized assisted suicide in 2001). Dr. Keizer, a long-time practitioner of euthanasia, who now works at an end-of-life clinic run by the Dutch Right to Death Society, is pleased with the slippery slope effect of euthanasia legislation, which has gradually expanded eligibility for euthanasia death. Dr. Keizer writes that he regards this slippery slope as a "beneficial progress" in the practice of euthanasia: "Every time a line was drawn, it was also pushed back. We started with the terminally ill, but also among the chronically ill it turned out to be hopeless and unbearable suffering. Subsequently, people with incipient dementia, psychiatric patients, people with advanced dementia, elderly who struggled with an accumulation of old-age complaints and finally [the] elderly who, although not suffering from a disabling or limiting disease, still find that their life no longer has content."

## **Amendments to Canada's Current Euthanasia Law**

C-7 proposes to expand the euthanasia law to delete the criterion that assisted suicide should occur in only those cases where there is a "reasonably foreseeable natural death". The removal of this criterion opens up euthanasia to those with chronic conditions, disabilities and mental health issues. As a result, in the near future, euthanasia in Canada will almost certainly be open to any person who feels their suffering cannot be addressed except through intentional death. Regrettably, the Board of Directors of the Canadian Psychiatric Association, on February 10, 2020, supported euthanasia for all patients whether or not they are capable of providing a valid consent because of, for example, schizophrenia or depression, etc., even though these are treatable.

## **Lack of Access to Care for the Disabled**

Another concern expressed by Herx, Cottle, and Scott is that Canadians are requesting euthanasia because of lack of access to proper care, and availability of disability supports. There are documented cases in which individuals have been told by health care providers to consider euthanasia as an "answer" to a perceived poor quality of life caused by a lack of healthcare resources to meet their needs. In short, the lack of support and societal inequality for those experiencing disabilities are now being used to justify the termination of their lives. The fact that a person's life can be ended, based solely on their disability, further stigmatizes and devalues their lives.

## **Reasons Why Patients Receive Assisted Suicide**

The official Health Canada report on euthanasia states that it is requested for the following reasons: Loss of ability to engage in meaningful life activities (82.1%) followed closely by loss of ability to perform activities of daily living (78.1%), inadequate control of symptoms other than pain or having concerns about it (56.4%). Disturbingly, 34%

reported being a perceived burden on their family, friends or caregiver as reason for the euthanasia request, and 13% reported isolation or loneliness.

Canada's rate of death by euthanasia has increased more rapidly than in other permissive countries. Eligibility criteria has expanded and safeguard mechanisms have been weakened. Pain, fear, loss of control and a sense of being a burden are not solved by hastening death by injection, but by providing palliative care that honours and protects our most vulnerable citizens at a most difficult time in their lives.

### **Court Ignores Experience of Other Jurisdictions**

The Supreme Court of Canada in its decision on February 6, 2015 to remove the prohibitions against assisted suicide in the *Criminal Code*, concluded that "it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately access decisional capacity". The court obviously was not aware, or, alternatively, chose to ignore, the experience of the ten jurisdictions which have already legalized assisted suicide or euthanasia. The data from these jurisdictions is frightening. A significant number of those who die by this method do so without giving their consent. Euthanasia and requests for assisted suicide are now provided to children and those suffering from depression or mental illnesses. Many of these deaths are not officially reported and there has been a steady increase of them. Irrefutable evidence also indicates that it is not physicians who are necessarily carrying out these deaths, but nurses, who do so frequently, without the knowledge and permission of a physician or the patient. Safeguards are ignored. Assisted suicide and euthanasia have become normalized and accepted as a part of medical care. Killing a patient, however, is not medical care.

There is no use pretending that Canada, when expanding the Supreme Court decision on assisted suicide, will avoid the traumatic effects of such a policy that have occurred in other jurisdictions. No matter how carefully guidelines are drafted, they will fail. The haste and enthusiasm to implement further expansion will leave a wake of vulnerable human beings.

### **Conscience Rights of Physicians Ignored**

The Supreme Court of Canada in its decision also made the statement, without supporting evidence, that "Nothing in this declaration would compel physicians to provide assistance in dying." The court has quickly been proven wrong on this point. The Colleges of Physicians and Surgeons of the provinces of Saskatchewan and Ontario have declared that any physician who, for conscience or religious reasons, may not wish to participate in assisted suicide, must refer a patient to another physician to carry out this procedure.

To coerce physicians to provide services that go against their religion or consciences is not acceptable. It is contrary to the Charter's right of freedom of conscience and religion. It is also a serious incursion into the professional standing of the physician. A proper balancing of the rights of physicians with the concept of patient autonomy, must

not result in the trumping of the rights of a physician in his/her medical practice. Such rights extend not only to refusing to perform assisted suicide and euthanasia, but the right not to be obliged to refer to other practitioners or third parties, who may be willing to provide such services. The reality is that the requirement to refer for assisted suicide or euthanasia procedures, to which the physician objects on the grounds of conscience or religion, compels that physician to violate his or her conscience by being a participant in the very act, the very procedure to which he or she objects in the first place.

### **Recommendations**

1. Palliative care must be designated as a “right” and equally funded in the Canada Health Act, similar to assisted suicide.
2. Conscience rights of all health care providers must be protected.
3. A reasonably foreseeable natural death, which is a safeguard, must be retained as a criterion for assisted suicide. The federal government is NOT legally required to remove this criterion as the Québec court decision to do so was made merely by a single judge on a lower court. That decision applies only in the province of Québec and is not binding federally.
4. Availability of support for the disabled must be a legal prerequisite before assisted suicide is offered.