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**THE EVANGELICAL FELLOWSHIP OF CANADA**  
is the national association of evangelical  
Christians, gathered together for influence, impact  
and identity in ministry and public witness.

## **QUEBEC'S BILL 52: Euphemisms for Euthanasia**

OCTOBER 2013



**EFC**

The Evangelical Fellowship  
of Canada

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“The Evangelical Fellowship of Canada believes that every human life is endowed with dignity and worth by our Creator.”

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## 1. Introduction

The Evangelical Fellowship of Canada (the EFC) believes that every human life is endowed with dignity and worth by our Creator. Life has value at all stages; terminal illness does not strip a person of his or her inherent worth, nor does physical or mental disability. We reject euthanasia and assisted suicide on moral grounds as the premature cessation of life that has value.

Every human life has intrinsic value and inherent dignity. The Supreme Court of Canada, in *Rodriguez v. British Columbia*, recognized that Canadian society is “based upon respect for the intrinsic value of human life and on the inherent dignity of every human being.” Mr. Justice Sopinka in that case referred to the sanctity of life as being one of the three *Charter* values protected in section 7 of the *Charter*.<sup>1</sup>

Quebec is the first province to draft legislation which would authorize euthanasia in its jurisdiction. Bill 52, *An Act respecting end-of-life care*,<sup>2</sup> was tabled in June 2013 by Véronique Hivon, Minister for Social Services and Youth Protection. Under the guise of “end-of-life care,” the bill requires all hospitals and health institutions in Quebec to formulate policies providing “medical aid in dying” (euthanasia) upon request of any person with a Quebec health card. The bill also provides patients the right to indicate in advance their directives on receiving end-of-life care.

In 2009, the *Collège des médecins du Québec* (Quebec College of Physicians) determined that under “exceptional” circumstances, euthanasia could be a viable option in end-of-life care.<sup>3</sup> The physicians’ pronouncement coupled with public opinion polls favoring euthanasia and assisted suicide led the National Assembly to form the Select Committee on Dying with Dignity (hereafter “Select Committee”).<sup>4</sup> The Select Committee’s mandate was to study the issue. This was accomplished in two ways: through the testimony of expert witnesses and the solicitation of constituent opinion on the topic.<sup>5</sup> The Select Committee released its report in March 2012.<sup>6</sup> The report proposed the drafting of legislation that would provide access to euthanasia (“medical aid in dying”) in Quebec.<sup>7</sup> Co-chairing the Select Committee was Véronique Hivon, who introduced Bill 52 the next year.<sup>8</sup> The bill is slated for debate in Fall 2013.

If Bill 52 passes, other provinces may follow suit. It is of national interest to prevent the passage of Bill 52 to avoid the potential establishment of legalized euthanasia in Canada. The potential reach of this legislation is wide, with other provinces potentially following suit. The EFC has a particular apprehension in light of Canada’s quick growing seniors population and expressed concerns about insufficient palliative care programs nationwide.<sup>9</sup> Halting the Bill’s progress in Quebec is a crucial step to ensure *Criminal Code*-prohibited euthanasia does not become a viable “treatment” option in Canada’s healthcare continuum.

## 2. Euthanasia vs. Assisted Suicide

### A. Background

Defining euthanasia is not straightforward; definitions vary by organization. The World Health Organization (WHO) is the United Nations’ global health authority whose research serves as an international standard for health issues. In 2004, WHO researchers formulated a glossary of terms for health care regarding the ageing population, including definitions for euthanasia and assisted suicide:

**Assisted suicide** – The act of intentionally killing oneself with the assistance of another who provides the knowledge, means or both.<sup>10</sup>

**Euthanasia** – A deliberate act undertaken by one person with the intention of either painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness or irreversible coma of another person. The term comes from the Greek expression for “good death”.<sup>11</sup>

The Canadian Medical Association (CMA) defines euthanasia and assisted suicide in their most recent policy update on the issue (2007):

Euthanasia means knowingly and intentionally performing an act that is explicitly intended to end another person’s life and that includes the following elements: the subject has an incurable illness; the agent knows about the person’s condition; commits the act with the primary intention of ending the life of that person; and the act is undertaken with empathy and compassion and without personal gain.

Assistance in suicide means knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.<sup>12</sup>

The CMA expressly prohibits the practice of euthanasia and assisted suicide. This does not interfere with patients’ established right to withdraw consent to treatment. Instead, the Association proposes a greater push to provide palliative care across Canada.<sup>13</sup>

The Evangelical Fellowship of Canada affirms these definitions, recognizing that euthanasia and assisted suicide both involve acts of murder/homicide and are not compassionate alternatives to end-of-life care. The oft-used term “mercy killing” is a semantic distraction from the issue at hand: administering medication to end a person’s life or providing that person with the knowledge or means to commit suicide will always be murder.

### **B. Canada’s Criminal Code**

The word euthanasia does not appear in Canada’s *Criminal Code*, but the action is referenced under the homicide provision:

**222.** (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.<sup>14</sup>

Culpable homicide, which is the case in euthanasia because the death is intended, is considered murder under s. 229<sup>15</sup> and is punishable by life imprisonment.<sup>16</sup>

Some argue that if patient consent is given, and certain criteria are met (incurable illness, extraordinary suffering, etc.) a doctor would only be acting in the best interest of the patient’s inherent rights to undertake their wishes. However, the *Criminal Code* explicitly addresses consent to death.

**14.** No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.<sup>17</sup>

The *Criminal Code* does include an assisted suicide provision in s. 241:

**241.** Every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.<sup>18</sup>

Canada's *Constitution Act of 1867* gives Parliament the power to legislate criminal law, including the *Criminal Code*.<sup>19</sup> The *Criminal Code* clearly criminalizes any behaviour that would fall under the definitions of euthanasia or assisted suicide. In 2008, Bloc Québécois MP Francine Lalonde's Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, attempted to remove prohibitions against euthanasia and assisted suicide from the *Criminal Code*. The Bill was defeated 228 to 59 in the House of Commons.<sup>20</sup>

### 3. Terminology: the Spin Doctors

#### A. Definitions

Understanding the definitions<sup>21</sup> involved in Bill 52 is essential to this discussion. Bill 52 itself provides few definitions, only for "institution," "palliative care hospice" and "end-of-life care." The majority of the definitions are excerpted from the Select Committee *Dying with Dignity Report* and the Select Committee *Dying with Dignity Consultation Document*<sup>22</sup> (a summary of the evidence and discussion that resulted from the two months of expert witness testimony the Select Committee heard).

**Assisted suicide-** "The act of helping a person commit suicide by providing him with the means to do so or information on how to proceed, or both."<sup>23</sup>

**Advance medical directives-** "Instructions a capable person gives in writing or otherwise concerning decisions to make on his care in the event he is no longer able to make such decisions."<sup>24</sup>

**End-of-life care-** "...palliative care provided to persons at the end of their lives, including terminal palliative sedation, and medical aid in dying."<sup>25</sup>

**Euthanasia-** "An act that consists of deliberately causing the death of another person to put an end to that person's suffering."<sup>26</sup>

**Medical aid in dying-** [our definition] Another term for euthanasia. It is a concept referenced in Bill 52 but not defined. As stated by the Select Committee's *Dying with Dignity Report*, the term was developed by the Select Committee to replace the term "euthanasia," as that term was deemed "emotionally charged."<sup>27</sup>

**Palliative care-** "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care:

Medical aid in dying - "...the term was developed by the Select Committee to replace the term 'euthanasia,' as that term was deemed 'emotionally charged.'"

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- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”<sup>28</sup>

**Palliative sedation-** “Administration of medication to relieve pain by rendering a person unconscious.”<sup>29</sup>

**Terminal sedation** (also referred to by the Select Committee as “**Continuous palliative sedation**”<sup>30</sup> and appearing in Bill 52 as “**Terminal palliative sedation**”<sup>31</sup>)- “Continuous administration of medication to relieve suffering by rendering a person unconscious until he or she dies.”<sup>32</sup> [Our note: euthanasia, in the form of administering a lethal dose of palliative care medications.]

### B. Psychology of Semantics

Bill 52 defines “end-of-life” care as “palliative care provided to persons at the end of their lives,” which is defined as encompassing “terminal palliative sedation” and “medical aid in dying” (both are forms of euthanasia). To conclude that both treatment options are palliative is contradictory to the World Health Organization’s definition of palliative care. Palliative care is not, by its meaning and purpose, intended to be used to end life. Causing someone’s life to cease is by very nature not palliative or care. Also, the Bill’s use of the term “terminal palliative sedation” is confusing because it is not found anywhere in the Select Committee’s prior reports. Though the term is considered self-explanatory, its use is intended to make euthanasia more palatable to the public by removing the negative connotations associated with the word “euthanasia” and by adding it as a treatment in the continuum of palliative care (an extension of palliative sedation not contributing to death, which is currently an acceptable medical practice).

The bill’s stated primary purpose is to establish the right to end-of-life care (euthanasia) in Quebec. However, it does so by adding euthanasia (illegal under the *Criminal Code*) to the classification of palliative care (legal medical practice) in an effort to promote the combined actions as medical care. It also uses new terminology (“terminal palliative sedation” and “medical aid in dying”) in an effort to connote continuing on the spectrum of medical treatment and evade *Criminal Code* liability, as

neither expression appears in the *Criminal Code* and thus are not explicitly prohibited.

It is of particular significance that the Select Committee developed the term “medical aid in dying” to replace “euthanasia” in an effort to avoid the negative stigma associated with the term. This manipulation of language is admittedly being used to encourage people to accept an act they would normally find morally reprehensible, a tactic that is common in the public debate about euthanasia. Many pro-euthanasia organizations have established or changed their names using positive framework language such as “Dying with Dignity,” “Aid in Dying,” and “Compassion and Choices”.<sup>33</sup>

An illustration of the effectiveness of language manipulation to further an agenda is evidenced in the following stem cell research example provided by the Life Information Website of New Zealand. In 2004, Leonard Zon, president of the International Society for Stem Cell Research (ISSCR) sent out a memo stating:

Nuclear transfer (NT) should be used instead of ‘therapeutic cloning’. Cells created by nuclear transfer should be described as ‘NT stem cells’ or ‘NTSC’. If an acronym is used for human embryonic stem cells, “HESC” should be used. If we use these terms consistently, the public, journals, newspapers and magazines will follow our lead and use adequate terminology. The negative connotation of the commercial term ‘therapeutic cloning’, makes a change in terminology necessary...<sup>34</sup>

Dr. Will Johnson, chair of the Euthanasia Prevention Coalition of British Columbia, similarly explains the danger of language manipulation:

The art of euphemism -- of sugar coating your verbal meaning -- has been raised to a syrupy peak by the proponents of euthanasia. When killing and suicide can be rebranded in the hearts and minds of average Canadians, the death lobby wins. What is truly being promised is the medical equivalent of a silent bullet in the head.<sup>35</sup>

Changing the rhetoric of a debate is a shrewd and useful tactic. Particular care should be given to the reality of what will occur should Bill 52 be passed: patients will die at the hands of their doctors under the guise of “end-of-life care.” And the inadequate criteria Bill 52 imposes to vet a person’s request for euthanasia mean Quebec’s legalization of euthanasia – through claiming it as provincially regulated medical treatment – will likely lead to the same trend toward broadening application in practice, then legislation, that has followed in every jurisdiction that has done so (see Section 6 below).

## 4. Bill 52

### A. Overview

The first paragraph of s. 1 of Bill 52 reads:

The purpose of this act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.<sup>36</sup>

“...all healthcare providers in Quebec will be required to provide access to euthanasia.”

The main components of the bill are: the right of all to end-of-life care (described as including terminal palliative sedation and medical aid in dying); guidelines for health facilities/institutions with regard to end-of-life care; the establishment of end-of-life care parameters, namely the criteria which must be met for a person to request end-of-life care; the establishment of the “Commission sur les soins de fin de vie,” or the Commission on End-of-Life Care, whose responsibility is to oversee the regulation of end-of-life care in Quebec; the right to request end-of-life care in advance medical directives; and lastly, the required changes to other Quebec legislation on passage of the bill.

### **B. End-of-life care provisions**

End-of-life care provisions are established in ss. 2-34. Sections 2 through 3 lay out general provisions. In s. 3(3), end-of-life care includes medical aid in dying and terminal palliative sedation. Subsections 3(1-2) determine which institutions the Bill applies to, as follows:

“institution” means any institution governed by the Act respecting health services and social services (chapter S-4.2) that operates a local community service centre, a hospital centre or a residential and long-term care centre...

“palliative care hospice” means a community organization that holds an accreditation granted by the Minister...<sup>37</sup>

Practically, this means all healthcare providers in Quebec will be required to provide access to euthanasia. Not only this, but s. 5 goes on to say that anyone “whose condition requires it” has the right to end-of-life care, and they can receive it at healthcare institutions or in their own homes.<sup>38</sup> Additionally, s. 7 stipulates that a person may still request euthanasia even if they have refused other treatment for their illness. The potential ethical implication is that doctors who are tasked with treating and rehabilitating patients will have to forgo providing beneficial treatments in favor of administering medication that will end their patient’s life.

Sections 8 through 17 set the rules for the establishments providing end-of-life care. Each facility is required to adopt an end-of-life care policy (including medical aid in dying) and to create a clinical program in its organization plan (including care for at-home patients). The director of each institution must also report to the board of directors yearly on the institution’s end-of-life care statistics: the number of patients administered “medical aid in dying,” the number of requests, and the number of refusals (including reasons the patients were denied).<sup>39</sup> Institutions and palliative care hospices must also adopt a code of ethics outlining the rights of end-of-life patients.<sup>40</sup> Section 17 also states that end-of-life care may be administered by nurses in a patient’s home.<sup>41</sup>

Sections 18 and 19 explain that health and social service agencies are to provide general rules on access to end-of-life care for the institutions and palliative care hospices located in their regions. The agencies must also provide end-of-life care information on their websites.<sup>42</sup>

Sections 20 through 24 list the powers of the Minister of Health and Social Services pertaining to end-of-life care, including the right to commission inspections of health facilities, the right to request statistical data on end-of-life care, the right to fine any institution for lack of compliance with an inspections, and the ability to pass these powers along to any health and social services agency.

In s. 25, informed consent guidelines are given for terminal palliative sedation. The patient – or caregiver – giving consent must be “informed of the prognosis, the irreversible and terminal nature of the sedation...”<sup>43</sup> This consent must be given in writing and filed under the patient’s hospital record.

Section 26 outlines the criteria for requesting medical aid in dying, as follows:

- (1) be of full age, be capable of giving consent to care and be an insured person within the meaning of the Health Insurance Act (chapter A-29);
- (2) suffer from an *incurable serious illness*;
- (3) suffer from an advanced state of *irreversible decline in capability*; and
- (4) suffer from constant and unbearable *physical or psychological pain* which cannot be relieved in a manner the person deems tolerable.<sup>44</sup> [our emphasis]

Apart from “full age,” which is 18, these criteria are loose and wholly subjective. What constitutes a “serious illness”? Mental illness could easily fall under that criterion, paving the way for broad numbers of people to request euthanasia. How will doctors decide what constitutes an “advanced state of...decline in capability”? Does decline in mental capability count? Will this clause allow patients with early or any stage of dementia to request euthanasia? Euthanasia is approached by proponents as a humane way to give people dignity in death, but where is the dignity in taking a life years early? Where is the dignity in assigning lesser value to the lives of people with “incurable serious illnesses”? What will happen when people suffering “unbearable... psychological pain” request euthanasia? Opportunities to treat symptoms and alleviate suffering will be bypassed by the decision to end a life.

Section 28 lists physicians’ duties surrounding medical aid in dying (m.a.d.): ensuring that the patient meets the criteria in s. 26; giving the patient the opportunity to speak with others about their decision, if requested; and, eliciting a second opinion from a physician that the patient does meet the s. 26 criteria. Section 29 requires the physician who verifies the eligibility for m.a.d. to administer the lethal dose personally and to attend to the patient until their death.

Section 30 sets out the required reporting steps for physicians not willing to administer m.a.d.; they are able to forward their request to the appropriate person, whose responsibility is then to find another physician willing to administer the treatment. Physicians are also responsible for alerting their respective council of physicians, dentists and pharmacists when they administer m.a.d.<sup>45</sup>

### **C. Commission sur les soins de fin de vie**

Sections 35 through 42 establish and direct the Commission on End-of-Life Care. The role of the Commission is to “examine any matter relating to end-of-life care,”<sup>46</sup> including reviewing the province’s execution of Bill 52 and reporting its progress to the Minister. It will consist of seven members: four health or social services professionals (including at least two physicians), one jurist (lawyer or judge), one user of an institution, and one member belonging to the ethics community (recognized as such by the academic community). The Government will select a chair and vice-chair, and the quorum at meetings is set at five members including the chair or vice-chair. Decisions are to be made by majority vote of those present. The Commission must also produce a report every five years on current end-of-life care in Quebec, to be submitted to the Minister.

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#### **D. Miscellaneous provisions**

In s. 44, health care professionals are given protection of conscience: the Act respects the rights of health care professionals to refuse to administer end-of-life care for “reasons of conscience.”<sup>47</sup>

Sections 45-58 provide the guidelines for advance medical directives with respect to end-of-life care. Patients are able to request m.a.d. in their advance directives. This right is governed by certain regulations, namely the presence of witnesses at a signing, what doctors are to do with the records, and revocation rights for the patient if changes are requested. An advance medical directives register is managed by the Minister.

#### **E. Amending provisions**

Sections 59-64 list the four legislative amendments Bill 52 invokes. These changes take place in the following documents:

- The Civil Code of Quebec
- The Code of Civil Procedure
- The Medical Act
- The Act Respecting Health Services and Social Services

#### **F. Final provisions**

Sections 65-70 provide final provisions, such as giving healthcare institutions one year from the date Bill 52 is passed to comply with its policies, requiring the Minister to report to the Government every five years on Bill 52, and appointing the Minister of Health and Social Services the overseer of Bill 52.

## **5. Legislative Discussion**

### **A. Overview**

If Bill 52 passes, the province of Quebec will infringe federal authority by violating the *Criminal Code*. Historically, this would not be the first time Quebec has challenged the federal government. In 1969, Canada’s first legalized abortion access came in the form of government Bill C-150, the *Omnibus Bill*, in 1969.<sup>48</sup> The bill did not decriminalize abortion, but allowed therapeutic abortions under certain criteria: the abortions had to take place in a hospital setting, and only after they received consent from a team of three doctors (deemed a Therapeutic Abortion Committee) who deemed the pregnancy dangerous to the health of the woman. From 1979 to 1982, several health centres publicly announced they would offer abortion services without the approval of a Therapeutic Abortion Committee, placing them in direct violation of the *Criminal Code*.<sup>49</sup> The then-Minister of Social Affairs for Quebec, Pierre-Marc Johnson, chose not to prosecute.

The Government of Quebec also questioned the constitutional legality of Bill C-6, *An Act Respecting Assisted Human Reproduction and Related Research* (AHRA), which came into effect in 2004 and was responsible for regulating reproductive and genetic technology in Canada.<sup>50</sup> Quebec’s Court of Appeal ruled that while some of the AHRA’s provisions fell within the boundaries of federal government’s criminal law authority,

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others overstepped provincial boundaries by attempting to regulate medical practice. The decision was appealed to the Supreme Court of Canada, where a split decision (4-4-1) led to the dismantling of much of the AHRA.<sup>51</sup>

### **B. Potential federal government responses to Bill 52**

Canada’s *Constitution Act, 1867* gives provinces the right to legislate on matters of healthcare. It also gives the federal government responsibility over matters of criminal law.<sup>52</sup> The Canadian legal system has a rule used to arbitrate matters of conflicting laws, known as the doctrine of paramountcy.<sup>53</sup> Should federal and provincial laws conflict; i.e., if a provincial law addresses matters that are of federal jurisdiction, the federal law would prevail and the provincial law would be suspended.<sup>54</sup> The provincial law is not deemed invalid or unconstitutional; it is solely deemed inconsistent, and as such is paralyzed while the federal law is in place.

Therefore, in this case, the federal government could seek through the courts to have the doctrine applied to Bill 52 and the provisions which allow euthanasia would likely be suspended, as they are simply provisions that seek to skirt existing *Criminal Code* prohibitions.

Another potential response by the federal government to Bill 52 is a constitutional reference to the Supreme Court of Canada (SCC), with the request for an injunction to hold the Quebec legislation inactive until the reference is decided. References are questions posed by a government to the appropriate court.<sup>55</sup> The court is then tasked with the responsibility of providing a legal opinion based on the questions put to it. While rare, this is a measure that governments have used in the past, in part, to seek clarification on contentious issues, as was done with the *Reference re: Same-sex Marriage*.<sup>56</sup> Technically, reference decisions are not viewed as legally binding, though historically they have been acted upon as though they carried the weight of other judicial opinions. References are typically used in matters of constitutional interpretation.

In this case, the federal government could request that the Supreme Court of Canada provide its opinion on whether Bill 52 is constitutional, if the doctrine of paramountcy should govern, and any other potential questions the government deems relevant.

Another option to counter Bill 52 would be giving direction to have federal crown attorneys attend in Quebec to prosecute any sections of the *Criminal Code* that Quebec provincial crown attorneys are directed not to prosecute (there is a federal provincial agreement on prosecution under the *Criminal Code*). Sean Murphy, a former RCMP officer from British Columbia, explains why the federal government would likely be loath to take this step in light of the political landscape between Quebec and Ottawa:

Even if the federal government decided to hire prosecutors it would face a significant practical problem. Federal prosecutors would be unable to act without the cooperation and assistance of the police, who investigate allegations and provide prosecutors with the evidence needed to support charges. Quebec police forces are under the jurisdiction of the provincial and municipal governments. While they are technically autonomous in their decisions about what to investigate, it is by no means certain that they would be willing to go against the public policy of the province on an issue as contentious as euthanasia.<sup>57</sup>

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To further explain, Murphy points out that the Select Committee’s *Dying with Dignity Report* makes a recommendation for the Attorney General of Quebec to compile and send “guidelines and measures” regarding medical aid in dying to the Director of Criminal and Penal Prosecutions. These stipulations would provide punitive immunity for any doctor who provides medical aid in dying (under the legislative criteria in Bill 52). Thus, once ensuring Quebec police are not entitled to charge doctors for medical aid in dying, they would not be able to comply with the federal prosecutors.<sup>58</sup>

A third option for the government to halt Quebec’s euthanasia practices is to consider the provisions of the *Canada Health Act* in order to determine if health transfer payments are being used for an improper purpose. If so, the federal government can choose to withhold these payments from the province.<sup>59</sup>

## 6. Ethical Implications: A Slippery Slope

### A. Introduction

In the history of civilizations, there were times when euthanasia or easy death would become more acceptable, and become increasingly common. A doctor would be called to heal and also to kill. The societal momentum of this “easy death” would then be challenged by an affirmation of the foundational value of human life. Countering easy death and the ambiguity about the role and intent of an attending doctor was the context of the advent of Hippocratic medicine around 400 BC (i.e. 2,400 years ago), where a patient knew a doctor who had taken the Oath would do no harm to the patient. Doctors were committed to healing their patients, not killing them. The Hippocratic Oath, based on the principles advanced by Hippocrates, rejects euthanasia and affirms the value of human life.<sup>60</sup>

Today’s Hippocratic Oath in Canada says, in part:

I will neither prescribe nor administer a lethal dose of medicine to my patient even if asked, nor counsel any such thing, nor perform act or omission with direct intent deliberately to end a human life.<sup>61</sup>

In the 1960’s, the Canadian Medical Association ceased use of the Hippocratic Oath.<sup>62</sup> The University of Ottawa’s Faculty of Medicine writes of the Oath as a “symbolism of an ideal: the selfless dedication to the preservation of life,”<sup>63</sup> rather than a standard applicable to today’s medicine. The Faculty says that certain statements in the Hippocratic Oath (namely those relating to abortion) are contradictory to modern views, passing it off as antiquated. “Given the complexity of medicine in the 21<sup>st</sup> century, an ancient oath cannot possibly encompass current values.”<sup>64</sup> However, some doctors see a renewed importance in embracing the Oath. In Canada, the Canadian Registry of Hippocratic Practitioners was formed to encourage doctors holding the Oath’s ethical values in esteem to counteract the culture’s secularization of medicine and to support them when they encounter practices or are asked to engage in practices that contradict those exemplified in the Oath.<sup>65</sup> In the United States, the American Hippocratic Registry<sup>66</sup> is an association of medical professionals who maintain the principles of the Hippocratic Oath, including refusal to participate in euthanasia or abortion, as outlined in the Oath.<sup>67</sup>

### B. The advent of euthanasia in the 20<sup>th</sup> century

In the last century, acceptance of euthanasia and assisted suicide has increased in pockets around the globe, though the practices are illegal in most countries. Germany

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was the first country to legalize euthanasia in 1935 under Adolf Hitler’s leadership, though the practice is not legal there today.<sup>68</sup> In 1949, American Psychologist Leo Alexander wrote in the *New England Medical Journal* of the shift in attitude that occurred in Germany after euthanasia’s legalization. He says:

It started with the acceptance of the attitude, basic to the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick.

Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans.<sup>69</sup>

Euthanasia in Nazi Germany became ultimately a eugenics issue, but the example of the shift in ideology is helpful in present day discussion of euthanasia. This shift in ideology is commonly referred to as the “slippery slope” argument, where acceptance of a previously unaccepted action (A) ultimately leads to a greater unacceptable action (B), therefore “A” must be prohibited as a preventive measure; i.e. legalizing euthanasia under specific criteria has led to the acceptability of involuntary euthanasia in other jurisdictions, therefore it should not be legalized in any form.<sup>70</sup>

In 1984, a Dutch Supreme Court case, in which a doctor euthanized a 95-year old patient, resulted in the doctor’s acquittal.<sup>71</sup> This case, along with impetus from the Royal Dutch Medical Association and a State Commission formed to review euthanasia in the Netherlands, led to a *de facto* decriminalization of euthanasia through the course of the 1980’s. Formal legalization of euthanasia and assisted suicide occurred in 2001 by a decision of the Dutch Parliament.<sup>72</sup> The 2001 legislation, which came into effect in 2002, established official state criteria for administration of euthanasia and assisted suicide, including access for minors<sup>73</sup> and those experiencing psychological suffering.<sup>74</sup> The Groningen Protocol allows the euthanization of severely ill or handicapped newborns.<sup>75</sup> Children ages 12-16 can request euthanasia, as long as they have parental consent.<sup>76</sup> Children aged 16-18 can request euthanasia without parental consent, as long as a parent is involved in the process.

After the initial decriminalization, certain safeguards were enacted, but international awareness of lax euthanasia procedure led to several government-commissioned studies, beginning in 1990 and recurring on average every five years afterward.<sup>77</sup> The first of these studies, published in 1991, is known as the R Emmelink Report.<sup>78</sup> Doctors were asked to classify their medical decisions concerning the end of life (MDEL’s) into three different categories:

- 1) Non-treatment decisions, the withholding or withdrawal of treatment in situations where the treatment would probably have prolonged life”;
- 2) Alleviation of pain and symptoms with opioids in such dosages that the patient’s life might have been shortened;
- 3) Euthanasia and related MDEL, the prescription, supply or administration of drugs with the explicit intention of shortening life, to include euthanasia at the patient’s request, assisted suicide, and life-terminating acts without explicit and persistent request.<sup>79</sup>

Researchers found that alleviation of pain and symptoms was the most commonly occurring form of medical decisions concerning the end of life among the doctors polled. When considering the cases where medicinal dosage was increased with the possibility that life may end as a result, only 40% of these decisions were discussed with the patient.<sup>80</sup> That means 60% of patients who received a medically administered overdose of pain alleviation medication leading to death did not give their consent to the decision.

In a 2012 study published in *The Lancet*, Dutch researchers analyzed the government's euthanasia statistics from 1990-2010 and specifically focused on 2010 statistics.<sup>81</sup> In 2010, 77% of all cases of euthanasia and physician-assisted suicide were disclosed to a review committee,<sup>82</sup> indicating 23% of cases went unreported. Interestingly, doctors in the unreported cases never used the terms "euthanasia" or "assisted suicide" to describe the situation, rather "ending of life," "alleviation of symptoms," or "palliative or terminal sedation."<sup>83</sup> Changing the terminology does not mean that doctors are not performing euthanasia. Terminal palliative sedation is intentional killing (euthanasia) by doctors, regardless of whether the stimulus for the action is the alleviation of pain. Researchers also noted that in the unreported cases of euthanasia, "the drugs used were hardly ever neuromuscular relaxants or barbiturates."<sup>84</sup> These two types of drugs are the drugs recommended by the Royal Dutch Association for Pharmacy and by the Euthanasia Review Committees.<sup>85</sup> The researchers attribute the lack of reporting and use of drugs other than those falling within protocol to, "a lack of clarity about or discrepancy between effects of drugs and intention with regard to hastening death."<sup>86</sup>

In startling similarity to the evolution of euthanasia in 1930s Germany, Dr. Herbert Hendin sums up the progression of euthanasia acceptance in the Netherlands:

The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to involuntary euthanasia (called "termination of the patient without explicit request").<sup>87</sup>

After the Netherlands, Belgium legalized euthanasia in 2002.<sup>88</sup> The criteria that must be met to request euthanasia in Belgium have widened in the last decade.<sup>89</sup> The Belgian Parliament is slated to approve a bill that will allow children access to euthanasia in certain cases.<sup>90</sup> The bill is also intending to allow persons with Alzheimers to request euthanasia while they are still mentally competent, allowing doctors to euthanize them when their disease advances, even if they otherwise appear healthy and content.<sup>91</sup> In 2012, Belgian twin brothers who were born deaf and diagnosed with onsetting blindness requested euthanasia from doctors at Brussels University Hospital.<sup>92</sup> Their request was granted and they were euthanized in December of that year, neither having suffered unbearable physical pain nor the diagnosis of a terminal illness.

Interestingly, researchers analyzing euthanasia in Belgium noted a trend similar to the occurrence in the Netherlands, where unreported cases of euthanasia were in fact cases of terminal palliative sedation, i.e physician administered overdose using opioids instead of the usual barbiturates.<sup>93</sup> Regardless of the doctor's intentions or methods, intentionally overdosing a patient is still euthanasia and must be treated as such.

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“What evidence is there that legalizing euthanasia in Quebec will not lead Canadian citizens down the same “slippery slope” as elsewhere?”

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In 2009, Luxembourg followed suit and legalized euthanasia and assisted suicide within a restricted legal framework.<sup>94</sup> Patients can request euthanasia if they are of age, “in a severe and incurable terminal medical situation,” and experiencing unbearable physical or mental suffering.<sup>95</sup> Patients can also request euthanasia in their advance medical directive.<sup>96</sup>

In Switzerland, physician-assisted suicide is legal but euthanasia is not.<sup>97</sup> Clinics providing assisted suicide have given people from countries where the act is criminalized the opportunity to fly to Switzerland and make their request; this is commonly known as “suicide tourism.”<sup>98</sup> There have been cries for increased regulation in Switzerland, but to no avail.

Select U.S. states, namely Oregon, Washington, Montana, and Vermont,<sup>99</sup> have recently passed laws allowing physician-assisted suicide, and in several other states similar attempts to pass such legislation have been unsuccessful.

What evidence is there that legalizing euthanasia in Quebec will not lead Canadian citizens down the same “slippery slope” as elsewhere? In the Select Committee’s *Dying with Dignity Report*, the members give justification for their belief that Quebec will maintain proper regulations on medical aid in dying:

In a democratic society such as ours, in which the National Assembly and the media provide effective checks and balances of government action, we are sure that any abuse would be denounced and thwarted. Moreover, the people and organizations opposed to any type of openness to euthanasia would be a part of the social control mechanism and provide one more safeguard.<sup>100</sup>

This language is smoke and mirrors. There is no proof that the media provides effective checks and balances of government action – in Quebec, The Netherlands, or Belgium for example – and even if the media speaks out about abuse, the legislature is not bound to address those concerns. The wide criteria Bill 52 establishes to request euthanasia suggest that organizations opposing euthanasia have not been able to convince the government to provide any safeguards.

In response to Bill 52’s introduction, then federal Justice Minister Rob Nicholson said:

The laws that prohibit euthanasia and assisted suicide exist to protect all Canadians, including those who are potentially the most vulnerable, such as people who are sick or elderly, and people with disabilities.<sup>101</sup>

Bill 52 will compromise the safety of the vulnerable. The above examples, especially in Belgium and the Netherlands where children can request euthanasia and doctors administer terminal palliative sedation without reporting the instance as euthanasia, give evidence that regulations and safety protocols inevitably loosen, paving the way for grave abuses of the system.

### **C. Suicide prevention and disability discrimination**

Access to euthanasia for those with an incurable illness (as per Bill 52’s specifications) raises another interesting question: Why are Canadians struggling with depression and other psychological disorders who contemplate suicide provided suicide prevention assistance, while patients with a terminal illness suffering “unbearable physical or psychological pain”<sup>102</sup> would be provided a means to end their lives by requesting euthanasia? Disability rights advocates have suggested this proposal would establish a form of reverse discrimination, where non-disabled people would be offered only

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one option (suicide prevention) while disabled people would be offered two options (suicide prevention and medically assisted death).<sup>103</sup> The root problem of such a discussion is a subjective valuation of life that selectively determines which lives are worthy of support and which are not.

The *Canadian Charter of Rights and Freedoms* enshrines the “right to life, liberty and security of the person.”<sup>104</sup> Freedom from discrimination on the basis of mental or physical disability is also enshrined in s. 15. The EFC has previously stated:

If euthanasia and assisted suicide only apply to those with disabilities, the law will violate the *Charter* because it does not provide equal protection of the law. It discriminates against those with disabilities by denying them protection from being killed. It may also be subject to a Charter challenge on the basis that it does not allow for those without disabilities to commit suicide.<sup>105</sup>

Suicide awareness in Canada is rising. Communities are responding to the effects of teen suicides by encouraging suicide awareness and prevention programs.<sup>106</sup> Bereaved spouses are encouraged to join grief groups.<sup>107</sup> The Canadian healthcare system currently provides policies and treatment options for patients who are suicidal, equipping healthcare workers with resources to prevent suicide.<sup>108</sup> These policies are a stark contrast to euthanasia legislation that would allow a patient to request euthanasia potentially before palliative psychological care or other care is provided to patients suffering from terminal illnesses.

How will our society make the distinction between those we encourage to live and those we help to die? Do persons with terminal illnesses rendering them disabled deserve to live more or less than the teen contemplating suicide because he is bullied by his peers? What if that teen is eighteen?

Another facet of this issue is whether a person’s illness and subsequent cognitive impairment or depression has an effect on their capacity to make an informed decision with regard to euthanasia consent.<sup>109</sup> Depression is the greatest common denominator among those who commit suicide in Canada; 60% of suicides occur in people suffering from depression.<sup>110</sup> Additionally, loss of judgment and reasoning are symptoms of dementia<sup>111</sup> that could lead patients to sign consent forms for euthanasia without clarity of thought or insight.

There are a lot of unanswered questions about this proposal that is termed euphemistically as “end-of-life care.”

#### **D. The conscience rights of health professionals**

Section 44 of Bill 52 grants health professionals the right to opt out of providing medical aid in dying for reasons of their profession’s code of ethics:

This Act does not limit the right of health professionals to refuse, in accordance with their code of ethics, to provide or take part in providing end-of-life care for reasons of conscience.<sup>112</sup>

There are several inherent problems with this provision. It is unclear whether the phrase “provide or take part” applies only to those actively administering medical aid in dying (doctors and authorized nurses), or whether it would extend to the health professionals (councils of doctors, dentists, and pharmacists, as outlined in s. 32) who are mandated by Bill 52 to establish clinical protocols for implementation of the treatment in their institution or referrals for m.a.d.<sup>113</sup> It is also unclear whether

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“Another potential problem concerning conscience rights is Bill 52’s lack of explicit protection against discrimination for medical practitioners who choose not to take part in m.a.d. procedures.”

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true protection of conscience objections is provided for in the fluid documents that comprise the codes of ethics for the professions concerned (witness even the commentary on the Hippocratic Oath above). Will there be protection for healthcare professionals who may not be actively involved in administering m.a.d. but would have ethical or moral objections to the legislative requirements to: a) refer and/or b) outline guidelines for the procedure in their facility and/or c) ensure implementation of those guidelines? Bill 52 does not provide a clear answer to this question.

Further, s. 30 requires physicians who refuse a request for medical aid in dying to notify the appropriate executive who will then forward the request to a physician willing to perform the procedure. The complication with this protocol is that doctors refusing to perform euthanasia for reasons of conscience may invoke those same reasons of conscience for not referring the request; i.e. they may see referral as compliance with and propagation of an act violating their conscience. The Canadian Medical Association’s policy on induced abortion addresses the issue of conscience in regard to abortion in this way:

A physician should not be compelled to participate in the termination of a pregnancy. [...]

A physician whose moral or *religious beliefs prevent him or her from recommending* or performing an abortion should inform the patient of this so that she may consult another physician.<sup>114</sup> [our emphasis]

The *Canadian Medical Association Journal* published a piece clarifying this policy in 2007, saying, should the situation occur where a patient requests an abortion or an immediate referral for abortion and the doctor declines on moral grounds, “You should also indicate that because of your moral beliefs, you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency).”<sup>115</sup> In this policy, the doctor’s conscience rights are respected by allowing him to decline the request as well as abstain from referring the patient to another doctor. The same rights of conscience should be extended to medical practitioners when receiving requests for m.a.d., if the practice becomes legal.

Another potential problem concerning conscience rights is Bill 52’s lack of explicit protection against discrimination for medical practitioners who choose not to take part in m.a.d. procedures.<sup>116</sup> No provision in Bill 52 would prevent institutions from penalizing doctors or nurses who refuse to participate, or denying them certain medical privileges. Would such doctors or nurses stand to lose opportunity for promotion in their places of employment, or worse yet, be discharged from their positions for refusal to participate in an act they find morally reprehensible? The lack of employment protection evidenced in Bill 52 is concerning.

### **E. A discussion of ethics and religion**

The CMA’s Code of Ethics (and each provincial College of Physicians and Surgeons has its own code) is “based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability.”<sup>117</sup> It states the core activities of medicine are to advocate for patients, continue education and research in the field, prevent and treat disease, relieve pain, and to encourage and restore health. Doctors are specifically tasked with caring for patients even when curative treatment is not possible.<sup>118</sup> When Canadian doctors are clearly encouraged to promote the health and well-being of patients, how will they reconcile requests to end the lives of their patients? The Christian Medical Dental Society explains the ethical conflict:

The health care system operates within an ethos of saving life. What will happen when society deems intentionally ending one's life to be as virtuous as fighting for one's life? Can two different ethics be supported simultaneously, or will one eventually win out over the other?<sup>119</sup>

Ethicist Margaret Somerville suggests that an increasingly secular society with an increased value on individual autonomy could be the reason for the societal shift toward euthanasia access.<sup>120</sup> This sentiment is exemplified in the Select Committee's justification for euthanasia in its *Dying with Dignity Report*:

The medical aid in dying option is compatible with changes in social values, medicine and the law. Fuelled by diverse ideas, our social values have shifted from religious or ideological beliefs to notions of personal liberty, respect for autonomy, inviolability and integrity of the individual, all consistent with the concept of medical aid in dying. In the last 20 some years, these values have been expressed, for example, by the recognition of the right to refuse or stop treatment, decisions that often hasten death. In addition, opinion polls in Québec have long shown strong support in principle for medical aid in dying, which is corroborated by the answers to our online consultation.<sup>121</sup>

Somerville says religious societal rejection of euthanasia has a simple origin: God told his people not to kill. Today, an emphasis on individualism means individual rights are taking precedence over potential harm or benefit to the community.<sup>122</sup>

As noted earlier, the EFC believes that every human life is endowed with dignity and worth by our Creator. Christians, and other religious communities, hold that life has value at all stages; terminal illness does not strip a person of his or her inherent worth, nor does physical or mental disability. Euthanasia and assisted suicide are rejected based on sacred texts and developed theologies on moral grounds as the premature cessation of life that has value.

The Supreme Court of Canada, in *Rodriguez v. British Columbia*, recognized that Canadian society is "based upon respect for the intrinsic value of human life and on the inherent dignity of every human being."<sup>123</sup> Mr. Justice Sopinka in that case referred to the sanctity of life as being one of the three *Charter* values protected in section 7 of the *Charter*. Every human life has intrinsic value and inherent dignity.

With reference to ethics surrounding palliative care, the *Dying with Dignity Report* includes doctor testimony:

Physicians [...] are still confused about the line between sedation and euthanasia, and even about intent [...]. The fact is that when terminal sedation is used, no doctor wants to see it go on for too long; in other words, we want it to be short, which is tantamount to hoping for death. Hoping for death without wanting to cause it but taking action that could hasten it blurs these ethical boundaries beyond recognition.<sup>124</sup>

Religiously informed and non-religiously informed viewpoints reason to the same conclusion: euthanasia must be seen for what it is, the intentional killing of another human being. If we begin to prize human autonomy over the value of human life, we will shift from a culture of life to a culture of death, and our most vulnerable citizens will be subject to the greatest risk.

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**EFC**

The Evangelical Fellowship  
of Canada

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## 7. Palliative Care

In addition to recommending the pursuit of euthanasia legislation, the Select Committee’s *Dying with Dignity Report* also exposes a substantial deficit in the comprehensiveness of palliative care in Quebec.<sup>125</sup> The report makes several recommendations for the Minister of Health and Social Services to improve access to palliative care across the province. However, none of these recommendations were addressed in Bill 52; euthanasia was simply added to the continuum of end-of-life care along with palliative care.

Specifically in Quebec, there were 685 palliative-care beds in 2012, which falls 110 beds short of the government’s minimum standard of 1 bed per 10,000 people.<sup>126</sup> With 25% of Quebec’s population anticipated in the 65 and older demographic by year 2031,<sup>127</sup> the need for sufficient palliative care will only increase in importance.

According to a 2010 Canadian Senate report,<sup>128</sup> palliative care would benefit 90% of Canadians who die. Yet the Canadian Hospice Palliative Care Association reports only 16-30% of dying Canadians receive end-of-life care.<sup>129</sup> This low number indicates Canada’s access to palliative care is lacking, and provincial healthcare programs should focus on increased accessibility to this form of end-of-life care.

The Canadian Medical Association’s current stance on palliative care is: euthanasia and assisted suicide should be rejected in favor of palliative care. The Association believes Canada needs to devote more funding to palliative care as a viable end-of-life care.<sup>130</sup> However, with a shift in rhetoric across Canada, the CMA will undoubtedly revisit their policy on the issues. Newly elected CMA president, Dr. Louis Francescutti, was quoted as saying the discussion around end-of-life care is “evolving naturally” and the CMA should be ready to approach the issue [euthanasia] as it arises.<sup>131</sup>

To conclude, Quebec’s access to palliative care is already insufficient. Lumping “medical aid in dying” under end-of-life care (previously consisting of only palliative care) means equal funding must be spent by the province to provide and regulate euthanasia and assisted suicide, potentially lowering the amount of money and effort that would otherwise flow to palliative care programs. Unlike medical aid in dying, palliative care is holistic and places the patient’s physical and psychological well-being front and centre. It aims to improve the quality of life for persons suffering, not to end it prematurely based on subjective criteria.

## 8. Conclusion

Bill 52 is a clever way for the province of Quebec to attempt to legalize euthanasia in Quebec. Couched in shiny new terminology like “medical aid in dying” and “terminal palliative sedation,” the bill seeks to circumvent federal prosecution for their legislation’s infringement of the *Criminal Code of Canada*.

By placing “end-of-life care” under the umbrella of palliative care, the province also demands equal funding and medical priority for access to euthanasia, which will diminish the funds available to an already-stunted palliative care program in Quebec. Those who value their quality of life and require palliative care services will suffer as a result of this legislation.

Bill 52 does not provide adequate safeguards for the protection of physicians' or other medical practitioners' conscience rights, nor does it provide enough regulation to keep euthanasia within the boundaries stated by the government (the specific criteria patients must meet in order to receive medical aid in dying).

To allow free access to euthanasia is to devalue human life.

The Government of Quebec is encouraged to withdraw this bill. If, however the bill proceeds for consideration by the *Assemblée nationale* then the elected representatives of the people in Quebec, their *députés*, are encouraged to stymie the passage of Bill 52, and instead focus on increasing the breadth of palliative care programs to ensure that every individual is given access to appropriate care that will increase their quality of life, not remove their life altogether.

If the bill is passed, the federal government is encouraged to do its part to shut down Bill 52.

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