

Who We Are

We are a coalition made up of the following organizations:

- Canadian Catholic Bioethics Institute
- Canadian Federation of Catholic Physicians' Societies
- Catholic Archdiocese of Toronto
- Catholic Health Alliance of Canada
- Catholic Organization for Life and Family
- Christian Medical and Dental Society of Canada
- Canadian Physicians for Life

Together we represent more than 110 healthcare facilities (with almost 18,000 care beds and 60,000 staff) and more than 5,000 physicians across Canada.

Our members come from diverse perspectives, but all agree that taking a patient's life violates at least one of the following:

- The Hippocratic Oath
- Our religious convictions
- Our mission and values
- Our founding principles
- Our Professional ethics
- Our creed, or
- Our deeply held conviction that healthcare should heal people, not hasten death.

We are committed to caring for people. Members of our Coalition are among the leaders in palliative care and care for the vulnerable across Canada. We will continue to serve all patients regardless of their views on the issue of euthanasia and assisted suicide (AS/E). We will respect their legal rights, even when we disagree with their decisions and the laws that allow them. We will deal with their requests respectfully and compassionately working as part of a larger healthcare team. However, we cannot help patients take their own lives, or do it for them.

We must not be forced to:

- Euthanize or assist with the suicide of a patient (AS/E)
- Refer for these procedures even to a third party
- Refer a patient to a government official (the Quebec referral model)
- Provide this in our nursing homes, hospices or hospitals

Our moral convictions form the core beliefs of who we are as healthcare workers and organizations. Forcing us to act against these convictions would deny us this deeply rooted tradition of service to the vulnerable and the care our patients expect from us. Not allowing us to offer care for others because we have a different belief or creed is discrimination. Discrimination on the basis of personal characteristics like gender, skin colour, religious belief or creed is illegal in Canada.

All other foreign jurisdictions that have legalized this practice of AS/E have provided legal conscience protection. We have suggested ways to respect patient's decisions without affecting caregiver's conscience rights. An explanation and legal summary is attached.

It is possible to respect both patient decisions and caregiver conscience rights

All other permissive foreign jurisdictions have conscience protection in their enabling statutes. There is no evidence that this has affected patient access. The following scenarios demonstrate how this could work.

Scenario One – *conscientiously objecting physician-patient interaction in office or in facility in which AS/E is provided*

Under this proposal the federal or provincial governments would create a process allowing patients to directly access an Assessment Advisor who could provide resources and support to patients and connect them to physicians and facilities that provide assessments for AS/E.

When a patient requests AS/E the physician must advise the patient of their conscientious objection to the procedure and referring for it. The physician will try to determine the source of the patient's suffering and identify possible treatments to assist with that suffering. If the patient still would like an assessment, the physician will advise that the patient could access that assessment directly. If the patient opts to do this, the physician would normally continue to be their physician in all other matters unrelated to assisted suicide and euthanasia.

In some cases, patients may not wish to access this assessment themselves or may not be able to do so due to health limitations, lack of family/caregiver support, etc. In these cases, the patient may request a transfer of care from the conscientiously objecting physician to another physician who has no objection to assist the patient to access this assessment. Transfers of this kind are commonplace within institutions. If it is requested by a patient in the community, the assessment advisor would be helpful in locating another doctor for the patient. This would end the relationship with the conscientiously objecting doctor. The patient's file would be transferred to the new doctor at the request of the patient.

Scenario Two – *patient in conscientiously objecting facility requests AS/E*

Health care workers in facilities that conscientiously object to providing AS/E work in an environment in which they are constantly treating people of diverse backgrounds and world-views. Often patients make decisions that are not in keeping with the values or beliefs of those caregivers or their organizations. Professional caregivers are respectful of the dignity of their patients even when they disagree with them. They will respond compassionately to their requests, allowing the patient to make the decisions that affect their own health care.

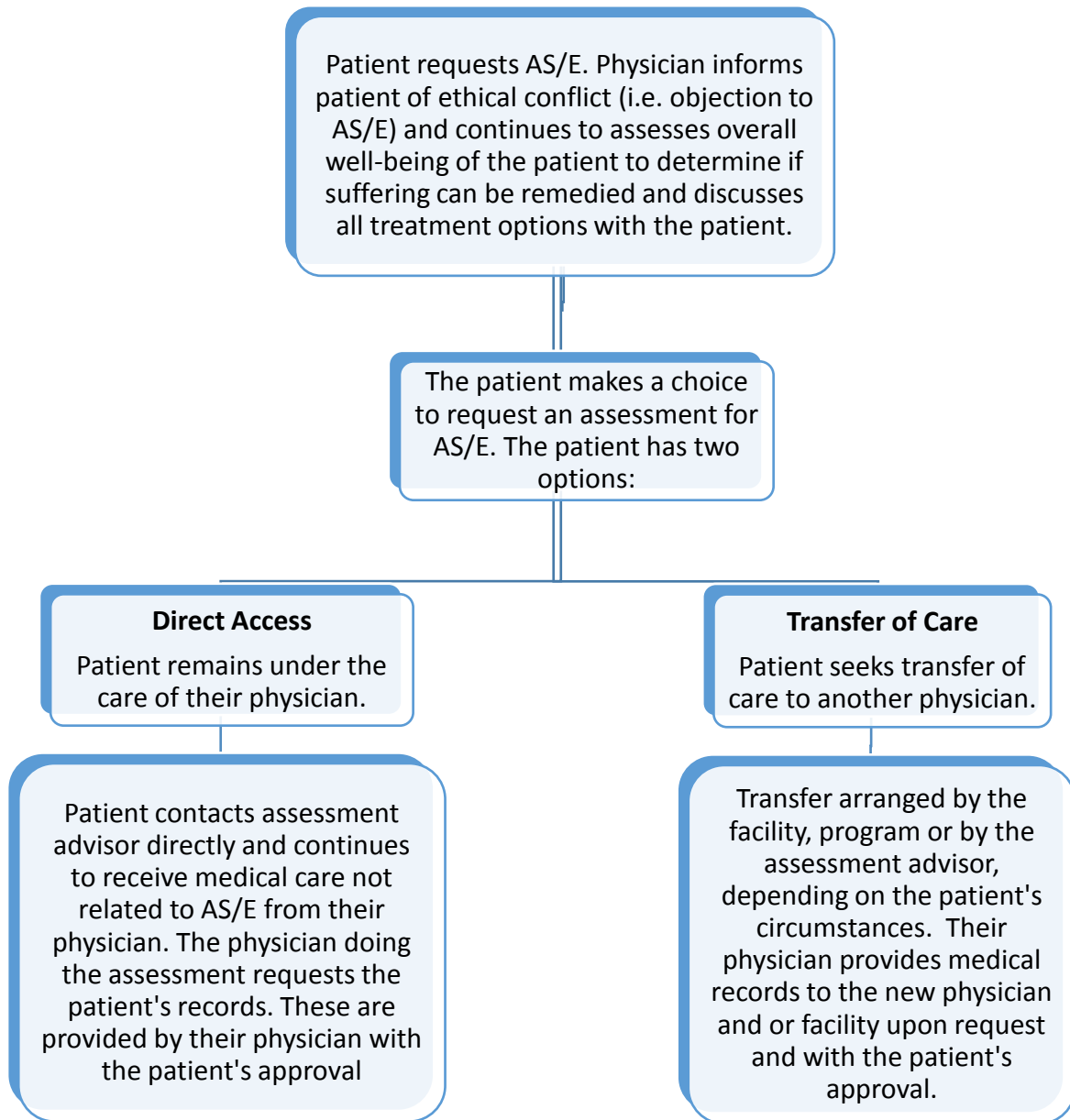
Healthcare facilities like hospitals, nursing homes and hospices should not be forced to provide AS/E on their premises. Patients admitted to these facilities would be advised upon entry of the conscientious objection policy of the facility. If the patient decides and requests to have AS/E they could be transferred to a facility that provides it. Patient transfers are common in healthcare because all facilities do not provide all procedures. They can be organized in a safe and respectful way that causes a minimum of disruption to the patient.

Members of our coalition are at the forefront of helping people with mental illness, disability and those at end of life. More resources are required to enhance these services. We have seen too many patients who have wanted to die due to sickness, disability, depression or despair, only to reconsider such a choice later when circumstances changed, or treatment was provided

People should not be forced into choosing AS/E because society has failed them.

Scenario One Flow Chart

Conscientiously objecting physician-patient interaction in office or in facility in which AS/E is permitted



The Canadian Medical Association has crafted a very similar proposal.

We are protected by the *Charter of Rights and Freedoms*

What is the problem with referral? In medicine, referral means recommending a particular course of medical treatment, or sending a patient to an expert to receive a particular treatment. The patient is still in the care of the referring physician. Referrals often include making an appointment for the patient and writing a letter of request and introduction. Referral of any kind is an act of participation, making our members accomplices to the objectionable procedure of AS/E.

Both Catholic and Evangelical theologians have indicated that the act of providing a referral for AS/E is formal cooperation in the death of the patient and the moral equivalent of performing the act itself. Forcing caregivers to refer requires them to break one of the Ten Commandments that guide them in their fundamental duty of service to God and their neighbour. Caregivers in this category are part of a religious minority who rely on the Charter of Rights and Freedoms (s.2) as protection against laws that would force them to refer for AS/E a procedure that they cannot in conscience participate in. If there is a requirement to refer, even to a third party (as in the Quebec model), this will be impossible for many physicians and will result in those health care workers being excluded from these occupations. This is a form of discrimination, which we believe is subject to a section 15 challenge under the *Charter*.

Organizations that operate healthcare facilities are protected

Forcing a faith based healthcare organization like a hospice, nursing home or hospital to provide AS/E on its premises would offend section 2(a) of the Charter. Faith based health care organizations are established on the founding principles and teachings of their faith, and have as their mission the care and service to the sick, vulnerable and the needy. These healthcare organizations are a direct extension of the faith communities and the groups that sponsor them. They represent the living expressions of service established by a religious community. Provision of healthcare is not only a service but a work of the sponsoring religious group and thus a religious act.

The Supreme Court has stated that religious freedom has both individual and collective aspects, and has upheld the right of faith-based institutions to be guided by their own religious and moral principles.

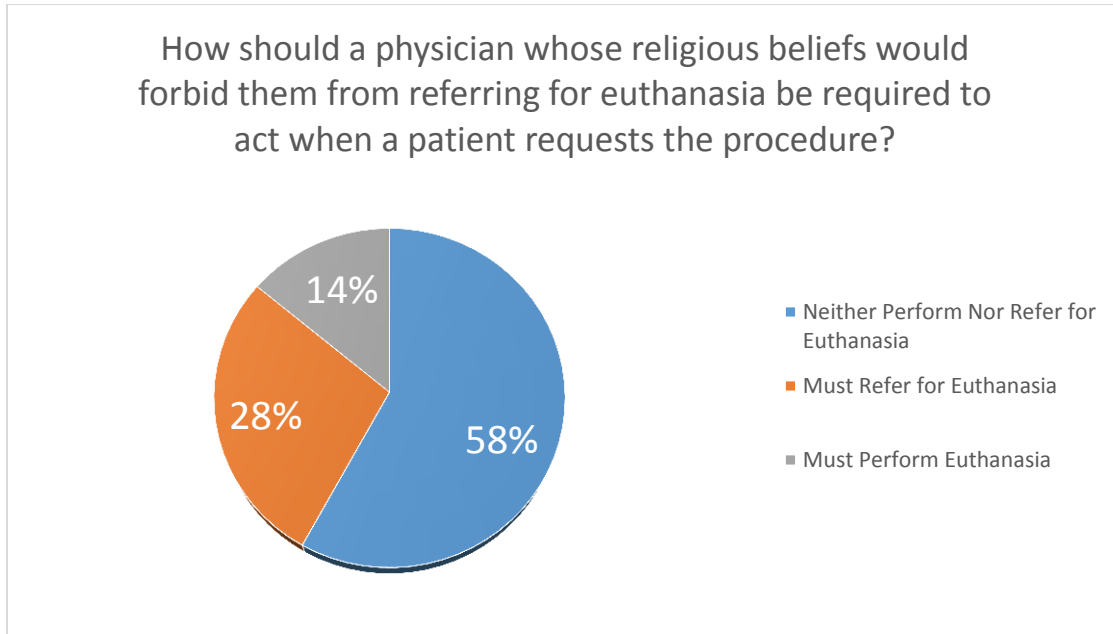
There is no conflict between patient's rights and physician or organizational rights

It has been suggested that a conflict of rights exists between the physician or organization and the patient. Firstly, the Supreme Court has never said that every doctor and every facility has an obligation to provide, or refer for every medical service. Specialization is one of the hallmarks of integrated medical care in Canada. Secondly, Scenarios One and Two demonstrate that there is another way to manage this perceived conflict. Forcing physicians to refer, or forcing facilities to perform, especially when it can be demonstrated that this is against their religious beliefs provides a *prima facie* case of infringement of religious freedom. Under the *Oakes* test, the government must choose the least restrictive option if its policy objectives require infringement on human rights. Therefore, how can forced referral be the least restrictive option if there are other viable options that are less restrictive?

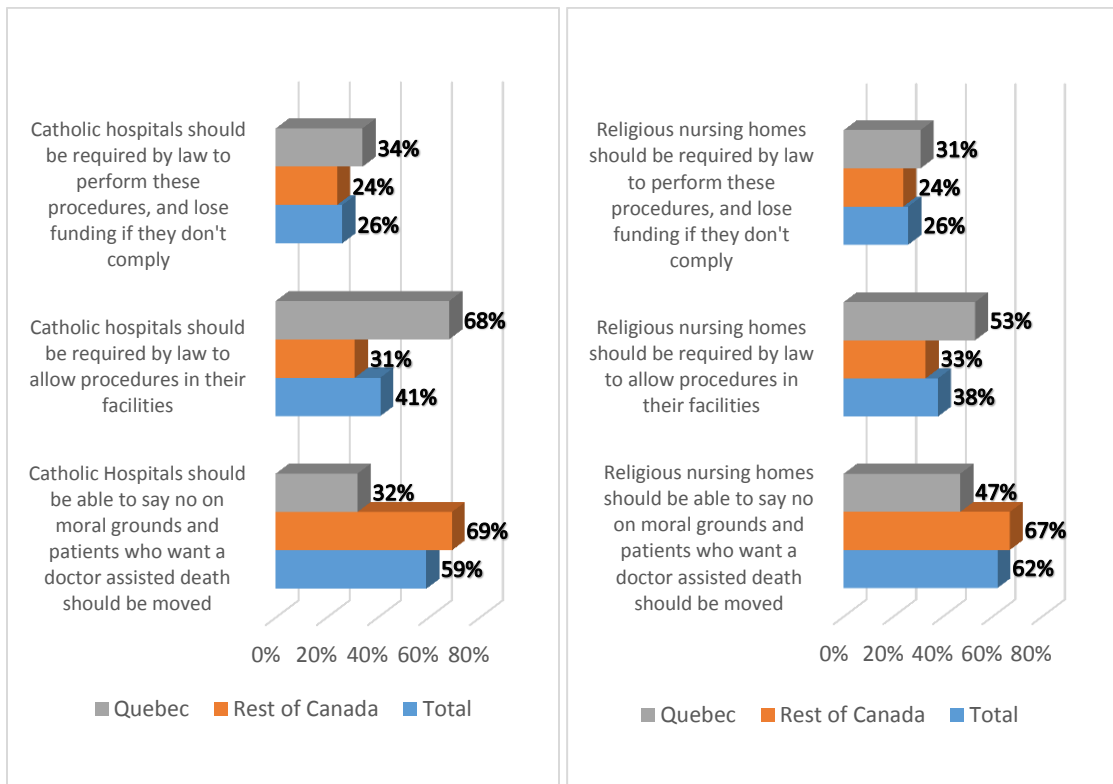
A full legal explanation of our position, produced by our legal counsel, is available on request.

Public opinion

May 2015 survey of 1,201 Canadians conducted by Abingdon Research



March 2016 survey of 1,517 Canadians conducted by Angus Reid



Other jurisdictions

No other foreign jurisdiction that has legalized euthanasia or assisted suicide has forced care workers or care facilities to act against their conscience, and both groups have been protected against discrimination for their moral convictions.

California: An act to add Part 1.85 (commencing with Section 443) to Division 1 of the Health and Safety Code, relating to end of life.

443.14 (2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.

443.15 (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

Supporting information can be found at:

<http://www.consciencelaws.org/publications/submissions/submissions-023-002-parl.aspx>

Detailed wording can be found at:

Belgium:

<http://www.consciencelaws.org/law/laws/belgium.aspx>

Luxembourg:

<http://www.consciencelaws.org/law/laws/luxembourg.aspx>

Washington State:

<http://www.consciencelaws.org/law/laws/usa-washington.aspx>

Oregon:

<http://www.consciencelaws.org/law/laws/usa-oregon.aspx>

California:

<http://www.consciencelaws.org/law/laws/usa-california.aspx>

Vermont:

<http://www.consciencelaws.org/law/laws/usa-vermont.aspx>