



## **Statement of Principles on Euthanasia and Assisted Suicide** Canadian Association of Social Workers

The Canadian Association of Social Workers (CASW) is a national federation with the mission promoting the profession of social work in Canada and advance social justice.

The profession of social work is founded on humanistic and equalitarian ideals. Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination and respect of individuality. “Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm” (CASW Code of Ethics, 2005).

CASW believes that there are several principles fundamental to the promotion of both humanitarian ideals and social justice, which must be considered in addressing the issue of euthanasia and assisted suicide. (Please see the attached Appendix for some useful definitions.)

These principles include:

1. The fundamental right of all persons to determine their own best interest. While self-determination can be compromised by the interest of the collective, a delicate balance is required between these two concerns. Central to self-determination is the commitment to informed consent. Professionals play a critical role in informed consent. It is imperative that informed consent be clearly defined whether through legislation or professional standards.
2. The right of all persons to participate in decisions affecting those they love, where that person is clearly unable to make critical decisions. The process of informed decision making is imperative and again, the professional must ensure that all requirements of informed consent are met, including the facilitation of an environment conducive to full informed consent. This must include clear boundaries between professional obligations and personal bias.
3. The necessity to view the issue of euthanasia in the broader context of care for persons who are dying. In our current economic milieu and social climate, with continued cost-cutting in our health care system, we must not incorporate the issue of patient choice in such a way that funds for palliative or chronic care are deflated. We must ensure that vulnerable persons are protected by ensuring this debate not be included in decisions about service reductions or cost-effectiveness.



4. The right of all persons to be provided with appropriate social, psychological and medical resources is essential at the end phase of life. The provision of these resources in a fair and equitable way ensures that people are given the opportunity to die with dignity. Services such as this include coordinated hospital or community based palliative care for those who wish to receive it. It is also critical that principles such as patient self-determination and informed consent not be compromised by discriminatory practices such as race, religion, sexual orientation, marital or family status, age or economic status.
5. The various positions of professionals and other interest groups need to be balanced with the needs of fundamental stakeholders in this issue. These stakeholders include ill persons themselves, their families (as defined by the ill persons) and other caregivers. It is important here to determine whom the ill person defines as his or her own family. The needs of those who have no identifiable family, or who have non-traditional families need to be fully explored in the context of assisted-suicide.

The social work profession has a long-standing role in advocacy, assisting those with little influence themselves be understood and accepted by society.

Those most deeply affected by the issue are the individual, the family, and the caregivers surrounding the individual. We need to further explore this issue through community dialogue, education, and research, which will enhance understanding and serve to develop new social policy. This, in turn, will encourage humanity, justice, and tolerance of divergent views in the development of sound policy.

We are all stakeholders in the creation of a society that values freedom of choice and self-determination in end of life care. It is now our task to envision what this means for us both individually and as a collective.



## Appendix A

### Glossary of Terms

When aid in dying is discussed publicly, a variety of terms are used. There is not always consensus on what these terms mean. This hampers any debate on the issues. To avoid confusion, this document has adopted the following terminology and definitions as taken directly from the Canadian Medical Association's "EUTHANASIA AND ASSISTED DEATH" (2014). Definitions regarding care at the end of life are as follows:

**Medical aid in dying** refers to a situation whereby a physician intentionally participates in the death of a patient by directly administering the substance themselves, or by providing the means whereby a patient can self-administer a substance leading to their death.

**Euthanasia** means knowingly and intentionally performing an act, with or without consent, 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.

**Physician assisted death (PAD)** means that a physician knowingly and intentionally provides a person with the knowledge or means or both required to end their own lives, including counseling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs. This is sometimes referred to as **physician assisted suicide**. Euthanasia and physician assisted death are often regarded as morally equivalent, although there is a clear practical distinction, as well as a legal distinction, between them.

**Palliative sedation** refers to the use of sedative medications for patients who are terminally ill with the intent of alleviating suffering and the management of symptoms. The intent is not to hasten death although this may be a foreseeable but unintended consequence of the use of such medications. This is NOT euthanasia or physician assisted death. Withdrawing or withholding life sustaining interventions, such as artificial ventilation or nutrition, that are keeping the patient alive but are no longer wanted or indicated, is NOT euthanasia or physician assisted death.

"**Dying with dignity**" indicates a death that occurs within the broad parameters set forth by the patient with respect to how they wish to be cared for at the end of life. It is NOT synonymous with euthanasia or physician assisted death. Advance care planning is a process whereby individuals indicate their treatment goals and preferences with respect to care at the end of life.

This can result in a **written directive**, or **advance care plan**, also known as a **living will**.

**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, assessment and treatment of pain and other symptoms, physical, psychosocial and spiritual.

