CHRISTIAN LEGAL FELLOWSHIP
Alliance des chrétiens en droit
INTEGRATING CHRISTIAN FAITH & LAW SINCE 1978
470 Weber St. N., Suite 202, Waterloo, ON, N2L 6J2 • Ph. 519-208-9200 • Fax 519-208-3600 • www.ChristianLegalFellowship.org

October 19, 2015

College of Physicians and Surgeons of Saskatchewan
500-321A-21st Street East
Saskatoon, Saskatchewan
S7K 0C1

Sent by e-mail to: communications@cps.sk.ca

RE: *Physician-Assisted Dying* - Policy Consultation

The College of Physicians and Surgeons of Saskatchewan ("CPSS") has invited feedback from its member physicians as well as the public at large concerning a new draft guidance document on Physician-Assisted Dying. Specifically, the CPSS has invited feedback on what guidance it should provide to physicians and patients that is consistent with the Supreme Court's decision in *Carter v. Canada*.

The Christian Legal Fellowship ("CLF") is a national charitable association that consists of approximately 600 lawyers, law students, professors, and others who support its work. As an association of Christian legal professionals, and an intervenor in *Carter v Canada* at all three levels of court, CLF has carefully studied the Supreme Court of Canada's decision and welcomes the opportunity to address the issues raised in this consultation process. CLF offers the following comments in order to explain the legal issues involved, which have serious implications for CPSS members.

CPSS Policy is Inappropriate and Outside its Jurisdiction

The CPSS assumes, as stated in the Background to this consultation, that it is "bound by the Supreme Court of Canada decision" and that if the CPSS does not adopt standards for physicians in deciding whether or not to participate in assisted suicide, "there will be no standards in Saskatchewan governing physician-assisted suicide."

With respect, these assumptions indicate some misunderstanding on the part of the CPSS about the nature of the *Carter v Canada* decision and the respective jurisdictions of Parliament, provincial legislatures, and medical regulatory authorities.

First, only Parliament has jurisdiction to delineate the scope of any exception to the general prohibition on assisted suicide in the *Criminal Code*. In *Carter v Canada*, the Supreme Court of Canada (SCC) affirmed (in paras. 49-53) that Parliament has authority to legislate with respect to assisted suicide under the *Constitution Act, 1867*. The SCC's finding that the existing, complete prohibition on assisted suicide

in section 241(b) of the *Criminal Code* violated the *Charter of Rights and Freedoms* does not change the fact that assisted suicide is a matter on which Parliament has authority to legislate. The *Carter* ruling does not turn assisted suicide, which has never been part of Canadian health care, into an ordinary health service to be regulated by medical regulatory authorities.

The CPSS's draft policy states, "In the absence of federal, provincial or territorial legislation related to physician-assisted dying, it falls to the medical regulatory authorities in Canada to develop standards or guidance for physicians within their provinces or territories." However, the absence of federal legislation cannot expand the jurisdiction of the provinces or, by extension, provincial regulatory bodies such as the CPSS.[1] Neither can the absence of provincial legislation expand the jurisdiction of the CPSS, since the CPSS's jurisdiction is derived from provincial statute and from no other source. Provincial law does not give the CPSS jurisdiction to determine when and under what circumstances assisted suicide falls with a judicially declared exception to the *Criminal Code of Canada*.

The CPSS must not attempt to instruct its members on how to interpret and apply the SCC's declaration in *Carter v Canada* in the absence of a legislative response from Parliament. Absent clear standards enacted by Parliament, the CPSS risks misinterpreting the SCC's decision in *Carter* and its members face potential criminal liability.

Policy Could Expose CPSS and its Members to Liability

Any physician who participates in assisted suicide could be subject to a wrongful death lawsuit from any family member or dependent who disagrees with the assessment of the physician. *A physician may be liable even if the physician follows CPSS policy*, because a court may find that the policy itself does not provide an adequate standard of care in the circumstances of an individual case. Only a provincial statute can protect physicians from civil liability.

By creating a policy on physician-assisted dying, the CPSS will signal to its members that they may participate in physician-assisted dying without facing legal risks. But the CPSS simply cannot guarantee that. Therefore, to put in place such a policy in the absence of federal or provincial legislation is to do its members a gross disservice. Instead, the CPSS must urge its members not to participate in assisted suicide until appropriate legislation is enacted.

It is important to note that CPSS is not obligated by the *Carter v Canada* decision to create a policy on physician-assisted death, and individual members of the CPSS have no obligation to provide such a service. Physicians are not agents of the state and are not bound by the *Charter*. While the CPSS may not prohibit its members from participating in assisted suicide, since it lacks jurisdiction to do so, it can and should discourage them from doing so absent clear legal standards set out in legislation.

The remainder of CLF's submissions focus on addressing the three specific questions raised by the CPSS for public input:

1. **Does the draft document adequately protect patients who seek physician assistance in ending their lives?**

No.

[1] Consider that in *R v. Morgentaler*, [1993] 3 SCR 463, the province of Nova Scotia's legislation prohibiting the provision of abortions outside of hospitals was struck down as being *ultra vires*—beyond the jurisdiction of—the province, even in the absence of any federal legislation. The absence of federal legislation did not make abortion a matter over which the province had jurisdiction to legislate (nor, by extension, provincial regulatory bodies). In light of *Morgentaler* (1993), the SCC in *PHS v Canada*, 2011 SCC 44, concluded that Parliament has authority to regulate "controversial medical procedures, such as human cloning or euthanasia" and that the provinces "might not have the power to do so" (para 69).

The draft policy states, "Given the finality of physician-assisted dying, significant safeguards and standards are appropriate to ensure that respect for patient autonomy is based upon carefully developed principles to ensure informed patient consent and consistency with the principles established by the Supreme Court of Canada." This is a significant understatement. Safeguards are not only "appropriate", they are, as the SCC recognizes in *Carter*, absolutely necessary.

Much of the factual debate in *Carter* was over whether it is even possible to provide adequate safeguards to protect vulnerable patients from abuse and undue influence. In 1993, the Supreme Court of Canada concluded that adequate safeguards were not feasible. In *Carter*, the SCC found that there is evidence from other jurisdictions to suggest that a complex regulatory regime containing strict conditions that are scrupulously monitored and enforced is capable of protecting vulnerable persons from abuse and undue influence. With respect, the "Requirements for access to physician-assisted dying" contained in the CPSS draft policy are grossly inadequate.

A particularly glaring problem in the draft policy is the voluntariness requirement, which states only that a physician must have "reasonable grounds" that the patient's decision to receive assisted dying is made without coercion or undue influence, that the patient has a clear and settled intention to end his or her own life after due consideration, and that the patient has requested physician-assisted dying him/herself, thoughtfully and repeatedly, in a free and informed manner. "Reasonable grounds" for believing undue influence and coercion are absent is a grossly insufficient standard. The presence of coercion or undue influence is extremely difficult to detect. A regular capacity assessment may reveal no signs of coercion or undue influence even if either is present. Whether or not an act or omission is illegal or criminal may depend on the presence or absence of coercion or undue influence, which is why this question would be subject to a detailed evidentiary inquiry in a court of law. Yet the draft policy offers no guidance on how to assess voluntariness and to rule out coercion or undue influence. Simply meeting with the patient may be inadequate and further investigation of the patient's circumstances may be necessary in order to rule out coercion or undue influence with a high degree of certainty.

We have briefly discussed some of the problems in the draft policy itself, but the CPSS ought to understand that the necessary regime for implementing the *Carter* decision, properly understood, is beyond the authority and capacity of the CPSS or any other medical regulatory authority.

The SCC briefly articulated the kind of circumstances in which an exception must be made to the assisted suicide prohibition in the *Criminal Code*. The Court did not outline any procedures and rules necessary to ensure that an exception to sections 14 and 241(b) of the *Criminal Code* does not devalue the lives of the sick or disabled or permit vulnerable persons to be pressured to end their lives. The existing prohibition in the *Code* was not upheld under section 1 of the *Charter* only because the SCC was persuaded that "a properly administered regulatory regime" (para 3) that "imposes strict limits that are scrupulously monitored and enforced" (para 27) is capable of protecting the vulnerable from abuse and error. The *Carter* decision clearly anticipates a *legislative* response. The SCC states that a complex regime must be enacted to give effect to its limited exception to the assisted suicide prohibition, but it does not outline such a regime itself, because: "Complex regulatory regimes are better created by Parliament than by the courts" (para 125).

The CPSS lacks jurisdiction to establish "strict conditions" delineating the scope of the exception to the general prohibition on assisted suicide. Even if the CPSS had jurisdiction to establish the conditions governing access to assisted suicide, it lacks the means to create "a properly administered regulatory regime" with "strict limits that are scrupulously monitored and enforced." The draft policy says nothing about how its proposed safeguards will be monitored and enforced and it therefore fails to adequately address the serious concerns about patient safety contemplated in the *Carter* decision.

2. Does the draft document provide adequate information to patients about what is required to obtain physician assistance in ending their lives?

At this stage, and especially in the absence of any legislation, it is inappropriate for a regulatory body such as the CPSS to purport to educate the public on the legal parameters governing access to assisted suicide. Its attempt to do so through its draft policy risks misleading patients, just as it risks misleading physicians. The draft policy wrongly conveys a sense of entitlement to assisted suicide as a health care service, which is itself contested. This question reveals the problematic nature of this consultation. The CPSS presumes to offer guidance to physicians on how to stay within the boundaries of criminal law, before legislation is even passed, and it presumes to inform patients of their entitlement to a service which the province is under no obligation to fund as a health care service.[2]

3. Does the draft document provide adequate guidance to physicians on what they should do if they are considering assisting a patient to die?
No.

The draft policy states, "A physician who assesses a patient for eligibility to access physician-assisted dying has an obligation to assess whether the patient meets the conditions established by the Supreme Court of Canada in the **Carter** decision", thereby recognizing that this is a *legal* issue—whether or not a physician commits a crime depends on getting this right. Physicians should not be burdened with interpreting a judicial declaration about the partial invalidity of a *Criminal Code* prohibition.

The draft policy cites the SCC's declaration that the patient must consent and must have a grievous and irremediable medical condition causing suffering that is intolerable to the patient, but fails to mention the statements in *Carter* that limit the extent of the SCC's declaration. The SCC decided only that the existing complete prohibition on assisted suicide violated the section 7 rights of "Ms. Taylor and of persons in her position" (para 56). It further clarified the scope of its ruling by stating that it was "intended to respond to the factual circumstances in this case" only and would not apply to "other situations where physician-assisted dying may be sought" (para 127). The factual circumstances of *Carter* involved a patient with advanced ALS who would eventually be completely physically incapacitated and incapable of taking her own life without assistance. Any physician who provides assisted dying in circumstances that are not factually similar to *Carter* may risk criminal liability.

The draft policy offers subjective and nebulous standards for when assisted suicide is permissible, stating:
"It is not possible to provide a practice guideline or treatment pathway which provides a detailed description of what a physician should do to ensure that those criteria are met. Patients will respond very differently to a grievous medical condition and will differ in the treatments which they are willing to accept. What is intolerable to a patient is subjective to the patient and what is intolerable suffering will significantly differ from one patient to another."

The policy goes on to say that physicians who are assessing a patient's eligibility for physician-assisting dying "***should*** consider whether to discuss" (emphasis added) such matters as symptoms, loss of function, progression of symptoms, future suffering and available treatment, and others. Again, this is matter of distinguishing between criminal and non-criminal activity. It is a life and death matter. The *Carter* ruling does not allow for such extremely subjective standards as the draft policy suggests. The draft policy is therefore misleading to CPSS members.

[2] The SCC's finding in *Carter* that the complete criminal prohibition on assisted suicide violates the *Charter of Rights* does not translate into a positive obligation on government to provide assistance in dying.

The *Criminal Code* makes it an offence, in section 245, to administer or cause to be administered to any person or to cause any person to take poison or any other destructive or noxious thing. This section of the *Criminal Code was* not invalidated in *Carter*. The draft policy cites the SCC's decision in *Carter* for the definition of physician-assisted dying as "the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient." However, in the context (para 40 of the SCC's decision), this is not an authoritative definition by the Court—rather, it was merely the appellants' understanding of what physician-assisted dying means. A physician administering a deadly substance to a patient could be guilty of violating section 245 of the *Criminal Code*. There is no defence of consent to this offence. Rather than communicating to its members that permissible physician-assisted dying includes the direct administering of a deadly medication by a physician, the CPSS should urge its members to await a legislative response to the *Carter* decision from Parliament before participating in the suicide of any patient.

Physicians' Freedom of Conscience

Finally, with respect to physicians' freedom of conscience, the draft policy states, "Within the bounds of existing standards of practice, and subject to the obligation to practise without discrimination as required by the CMA Code of Ethics and human rights legislation, physicians can follow their conscience when deciding whether or not to provide physician-assisted dying." The CPSS's current Conscientious Objection Policy, meanwhile, does not apply to physician-assisted dying (see section 2, "Scope"), but simply notes that this is an issue that "may be revisited by the College at a later time." CLF urges the CPSS to make it clear in its policies that no physician is required to participate in assisted suicide, either directly or by providing referrals.

Recommendations

In light of the many legal issues and areas of potential liability outlined above, CLF submits that the existing draft guidance on Physician Assisted Death is inappropriate, unworkable, and most importantly, outside of the CPSS jurisdiction. CLF urges the CPSS to abandon this draft document and to delay further consultations on this topic until after Parliament provides a legislative response to the *Carter* decision, for the reasons discussed above.

CLF would be pleased to provide further assistance in any way the CPSS believes would be appropriate.

Thank you for your consideration of our submissions.

Sincerely,

Derek Ross

Derek B.M. Ross, LL.B., LL.M.
Executive Director

John Sikkema, LL.B.
Legal Counsel

CHRISTIAN LEGAL FELLOWSHIP / Alliance des chrétiens en droit
www.christianlegalfellowship.org