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Secretariat to the External Panel on Options for a Legislative Response to Carter v. Canada /
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Ottawa (Ontario) K1A 0H8

Re: Written Submissions of the Christian Legal Fellowship to External Panel on Options for a Legislative Response to *Carter v. Canada*

The Christian Legal Fellowship (CLF) welcomes the opportunity to address the issues raised in the External Panel's consultation process through this its formal submissions to the Panel.

CLF, founded in the mid-1970`s and incorporated in 1978, is a national charitable association that consists of approximately 600 lawyers, law students, professors, and others who support its work. CLF's members include lawyers who practice in the areas of criminal law and health law as well as lawyers who are employed by and/or represent organizations operating long-term care homes, health care facilities, and homes for people with disabilities. CLF is also an NGO with special consultative status with the Economic and Social Counsel of the United Nations and reports to the UN on CLF's involvement in matters of human rights in Canada. CLF was an intervenor in *Carter v Canada* at all three levels of court and has carefully studied the Supreme Court of Canada's (SCC) decision. These submissions emphasize the limited scope of the *Carter v Canada* decision and the need for Parliament to clearly understand and fulfil its responsibilities with respect to the matter of assisted suicide and euthanasia.

Executive Summary

Parliament only has a few months to put legislation in place before *Carter* takes effect, a practical reality that Parliament must address immediately by requesting more time from the SCC and by fast tracking a notwithstanding clause bill to maintain the current prohibition for the time being.

Members of Parliament have a responsibility to learn the reasoning underlying the outcome in *Carter*. Parliament should examine the *Carter* ruling in depth and consider the options for a legislative response in light of what *Carter* actually decided. The SCC in *Carter* did not impose a value judgement that assisted suicide and euthanasia are good for society and must be provided by the government through physicians to the public. Rather, the SCC simply ruled that a total ban was a broader than necessary means for achieving Parliament's legislative objective—which the SCC interpreted as protecting vulnerable persons from being induced to commit suicide in a moment of weakness.

The SCC's interpretation of the objective of s. 241(b) of the *Criminal Code* is binding only with respect to that provision as it is currently worded, not with respect to future amendments or enactments. Nothing in *Carter* precludes Parliament from banning assisted suicide pursuant to other legislative objectives and Parliament ought to consider a complete ban as a means of achieving other objectives besides preventing the abuse of vulnerable persons, in the narrow sense that *Carter* understands vulnerability.

Short of a complete ban, which remains the best legislative option, Parliament should enact a strictly limited exception to the general prohibition on assisted suicide, along with a comprehensive regime detailing safeguards, reporting, and oversight mechanisms. Parliament's criminal law power affords it the authority to establish an administrative and enforcement regime necessary to give effect to the general prohibition and the accompanying limited exception. Judicial approval must be given in every case, only where the legal conditions and procedures are met, and consent must in every case be reliably obtained and recorded.

Finally, Parliament must protect physicians' (and others') freedom of conscience. Short of maintaining a complete prohibition on assisted suicide and euthanasia, Parliament should make it an offence to pressure any person to participate in it, directly or indirectly. Whereas the degree of participation required of a health care professional in providing health care services may be a matter of balancing professional duties with reasonable accommodation of religious and conscientious beliefs, pressuring someone to participate in assisted suicide or euthanasia is such a severe affront to human dignity that it ought to be an offence.

1. Parliament needs more time to fully and adequately examine this issue

Canada has just elected a new Parliament. The legislative agenda has been reset. The task still facing Parliament in the wake of the Supreme Court of Canada's *Carter v Canada (AG)*[1] ruling is to craft a new assisted suicide law, review it, and pass it, by February 6, 2015.

On February 24, 2015, Justin Trudeau introduced a motion to appoint a special Parliamentary committee to study the SCC's ruling, which was voted down. At that time, Mr. Trudeau raised concerns about the limited time Parliament had to respond to the *Carter* ruling:

> Our responsibility is to create new legislation, even though the process may be difficult and may make some people uncomfortable. [...] The Supreme Court—perhaps taking into account the contentious nature of this process—judiciously set a deadline and gave us one year to draft legislation on physician-assisted death. Given this is such a deeply personal and controversial issue, one year is hardly enough. We are not talking here about an insignificant amendment to a minor law. When Quebec decided to begin drafting its own legislation on physician-assisted death, there were four and a half years between creating a new multi-party committee and passing the legislation. During those four and a half years, one full year was spent on holding hearings and public consultations, as well as proposing and debating amendments. It took four and a half years in the Quebec National Assembly, including one full year of consultations and debate. The Supreme Court has given us 12 months, which is reasonable, but with the summer recess and the fall election, that gives barely more than 12 sitting weeks for us parliamentarians. That gives us enough time to do this, but no time to waste.[2]

[1] 2015 SCC 5 [*Carter*].
[2] Justin Trudeau, "Opposition Motion—Special Committee on Physician-Assisted Dying", Parliament of Canada, Feb. 24, 2015, online: <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=7854067>.

The *Canada Elections Act* mandated that the next general election would be held no later than October 19, 2015.[3] Now, post-election, and eight months since Mr. Trudeau made the above statement in the House of Commons, there is certainly not enough time.

The CBC recently reported that "a senior Liberal source" has indicated that the new government "will consider asking the Supreme Court for at least an additional six months to come up with new laws around doctor-assisted suicide".[4] CLF recommends a longer extension period, to ensure Canadians are widely consulted and stakeholders are given the opportunity to be fully heard on this important issue. In case the request is not granted, however, Parliament should also fast track a notwithstanding clause bill to keep the current prohibition in place, at least temporarily, giving Parliament time to examine the issue in depth.

The recent consultation of the College of Physicians and Surgeons of Saskatchewan illustrates the problems with allowing *Carter* to take effect before any legislation is in place. The CPSS appears prepared to take upon itself the task of instructing physicians how to provide "aid in dying" in line with *Carter*'s partial invalidation of a *Criminal Code* prohibition. This is untenable, for the reasons set out in CLF's submissions to the CPSS (attached as Appendix "A").

2. Parliament should re-enact a complete prohibition

The stated mandate of this Panel is to provide "a final report to the Ministers of Justice and Health that outlines key findings and options for a legislative response for consideration by the Ministers." One of the options for a legislative response that must be carefully examined by the Ministers is re-enacting a complete prohibition on assisted suicide. This is a legitimate and constitutionally sound option that has been overlooked by many commentators, in part due to misunderstandings about the *Carter* decision. The SCC's interpretation of the objective of s. 241(b) of the *Criminal Code* is binding only with respect to that provision as it is currently worded, not with respect to future amendments or enactments.

[3] SC 2000, c 9, at section 51.1.
[4] CBC News, "Justin Trudeau to move forward with ambitious agenda by year's end," October 27, 2015, online: <http://www.cbc.ca/news/politics/justin-trudeau-to-move-forward-with-ambitious-agenda-by-year-s-end-1.3291425>.

a) What *Carter* decided

In *Carter*, the SCC did not impose a value judgement that assisted suicide is good for society and must be provided by the government to the public. Rather, it ruled that a total ban was a broader than necessary means for achieving Parliament's legislative objective. The SCC considered the objective to be protecting vulnerable persons from being induced to commit suicide in a moment of weakness. The SCC went on to find that there are less restrictive means available for achieving that objective, means involving reliance on the expertise of physicians to sort out who is vulnerable and who is not.[5]

While the SCC concluded that a complex regulatory regime involving physician assessments can sort out who is vulnerable and—provided that strict safeguards are enacted and "scrupulously monitored and enforced"—protect vulnerable persons from abuse and error, the legalization of assisted suicide has broader ethical, social, and societal effects that were not addressed in *Carter*, and which call for its complete prohibition. Nothing in the SCC's *Carter* ruling precludes Parliament from banning assisted suicide pursuant to other legislative objectives, provided that a complete prohibition is not an arbitrary, overbroad, or grossly disproportionate means of achieving its objectives.[6]

b) The basis for a complete ban

The legal, moral, and constitutional principle underlying a complete ban is the equality of persons and the inviolability of human life. The inviolability of life is the principle that the *intentional* taking of all human life is wrong without exception, no matter whose life it is, no matter what the circumstances.[7] The inviolability principle does not create any obligation on an individual or a society to take every possible step to *prolong* life. It respects the right of a person where that treatment is futile or overly burdensome. It is a cornerstone of Western civilization, is evident in ancient Greek philosophy and Roman law, and was

[5] *Carter*, *supra* note 1, at paras 27, 105-106, and 121.
[6] The objective of a law is Parliament's objective. See *Carter*, *supra* note 1, at paras 29 and 37.
[7] *Carter v. Canada (AG)* 2012 BCCA 886, paras 272-282; *Rodriguez v. British Columbia (AG)*, [1993] 3 SCR 519, at para 125 [*Rodriguez*].

received into the common law long before it was constitutionalized as the right to life in s.7 of the *Charter* and held to inform the principles of fundamental justice.[8]

A complete prohibition can be maintained by specifying in the law itself that upholding the inviolability of human life is the purpose of the new law, not *merely* the protection of vulnerable people from abuse, as the SCC interpreted the purpose of the existing law. Parliament can choose to prohibit certain conduct both because of the wrongness of the conduct and in order to prevent accompanying harms.[9]

c) The immeasurable benefit of a complete ban

The protection of vulnerable people that results from a complete ban on assisted suicide may be considered a secondary objective of the law, or simply a beneficial side effect. In this sense, a prohibition on assisted suicide functions in the same way as the prohibitions in *R v Sharpe*[10] and *R v Butler*[11]. The SCC found in *Sharpe* that the prohibition against possessing child pornography protected children because "in a larger attitudinal sense [the law] asserts the value of children against the erosion of societal attitudes towards them."[12] In *Butler*, the prohibition on obscene materials was characterized as countering harm to women not only through direct prohibition, but also indirectly through countering harmful cultural attitudes towards women. Similarly, an assisted suicide prohibition protects vulnerable groups directly though

[8] See John Keown, 'A Right to Voluntary Euthanasia? Confusion in Canada in *Carter*', 28 Notre Dame Journal of Law, Ethics & Public Policy (2014) 1 – 45 at 4-5. The inviolability principle has also been posited in Article 2.1 of the *European Convention of Human Rights* ("Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally") and in Article 3 of the *Universal Declaration of Human Rights*. See also *Rodriguez*, *ibid*, at para 125 (per Sopinka J).

[9] Consider the law of assault as an example. Physical contact with another person is generally not assault where there is consent, but nobody is entitled to consent to the infliction of serious bodily harm. Justice Gonthier, for the majority of Supreme Court in *R v Jobidon*, [1991] SCJ No 65 (QL) , explained that this rule acts as a deterrent against consensual fighting and discourages fighting in general, thus also protecting those who do not consent to a fight from physical aggression (para 114). Gonthier J. also said: "Wholly apart from deterrence, it is most unseemly from a moral point of view that the law would countenance […] the sort of interaction displayed by the facts of this appeal. The sanctity of the human body should militate against the validity of consent to bodily harm inflicted in a fight" (para 115). The law can and does limit autonomy for moral reasons, while simultaneously promoting various policy objectives. By deterring aggression in general, the law of assault has the beneficial effect of protecting the autonomy and bodily integrity of those who would not consent to a fight. Yet the "moral point of view" is the primary basis for vitiating consent to assault causing serious bodily harm. The law of assault is about more than protecting personal autonomy. By contrast, in *Carter*, although section 241(b) says nothing about consent, the SCC decided that the existing prohibition is about protecting vulnerable persons from abuse and nothing more.

[10] 2001 SCC 2.

[11] [1992] 1 SCR 452.

[12] *Supra* note 10, at para 82.

prohibition and indirectly by maintaining a cultural attitude that every life is equally valuable.[13] Justice Sopinka in *Rodriguez* recognized that s. 241(b) if the *Criminal Code*, like s. 14, is grounded in the state's interest in protecting life and not allowing human life to be depreciated.[14]

In its submissions to the Court of Appeal in *Carter*, CLF pointed to the work of psychologist David Masecar, who argues against "[c]ommunity normalization of 'suicide as a solution' to problems" and warns that normalization may lead "children and youth" to "see suicide as [an] acceptable way of problem solving."[15] Note that although the SCC concluded that abuse could be avoided through adequate safeguards and oversight, the reasons for concern go beyond abuse. Even if new rules setting out the circumstances in which assisted suicide is permissible are always followed perfectly, the normalization of suicide may result. Another benefit of maintaining the complete prohibition, therefore, is to maintain a culture that discourages suicide as a way to end suffering.

Prohibition supports the medical ethical culture against killing. The risk of permitting assisted suicide or voluntary euthanasia at all is that the culture against killing will erode. Again, the concern is not simply that a new law permitting assisted suicide in certain circumstances will be abused or disobeyed, it is that medical culture will shift towards favouring assisted suicide where legally permissible.

Finally, prohibition remains the best means available for protecting the vulnerable. The SCC recognized that there are risks inherent in legalizing assisted dying, risks that cannot be eliminated entirely, but only "very substantially minimized".[16] The broader social and societal concerns involved in legalizing assisted suicide do not factor into the SCC's judgement. Once the legislative objective was interpreted by the Court as protecting vulnerable people, the rest of the judgement became a myopic inquiry into whether or not there is a less restrictive means of substantially achieving that objective. The Court also adopted a fractional view of what it means to be vulnerable. Doctors may be able to assess capacity reliably. Undue influence is more difficult to detect and may go undetected in many cases, even by physicians. Beyond

[13] 2013 BCCA 435 (Factum of the Intervenor CLF, at paras 4-6).
[14] *Rodriguez*, *supra* note 7, at 595.
[15] 2013 BCCA 435 (Factum of the Intervenor CLF, at para 4).
[16] *Carter*, *supra* note 1, at para 27.

coercion and undue influence, a person's decision to request assisted suicide may be the result of a wide variety of factors or influences, internal and external, interpersonal, familial, institutional and cultural. These complex human realities are not accounted for in *Carter*, which is narrowly focused on ensuring that assisted death, where it is requested, is requested autonomously.

The SCC mentioned that "competing moral and societal benefits" of the prohibition are appropriately considered only under section 1 of the *Charter*, not section 7.[17] However, in its section 1 analysis in *Carter*, the SCC's main focus was on the question of whether physicians are able to reliably assess competence, voluntariness, and non-ambivalence in patients, and the feasibility of minimizing risk of abuse through safeguards.[18] Moral and societal concerns, including upholding longstanding and foundational societal values, carried little if any weight. Parliament's task is to consider not only individual rights, but also the common good, which entails more than ensuring that people comply with the rules before assisting in someone's suicide.

3. Short of prohibition, Parliament must exercise its jurisdiction to enact strict limits and safeguards that apply nationally, not deferring to provinces

a) Assisted suicide remains a criminal law matter

The *Carter* ruling does not turn assisted suicide into an ordinary health service to be regulated by the provinces. It has never been part of Canadian health care. Sections 14 and 241(b) of the *Criminal Code* were within Parliament's criminal law power[19] to enact and do not interfere with the "core" of any provincial head of power.[20] It remains a "matter" falling within Parliament's criminal law jurisdiction.

Parliament must not leave this matter up to the provinces. Mr. Trudeau had it right when he said in the House of Commons, "Our responsibility is to create new legislation, even though the process may be difficult…" Parliament is responsible. There is a risk that if Parliament fails to respond, Canada will end up with a legal vacuum on assisted suicide. The provinces may lack jurisdiction to enact strict limits, given that assisted suicide is historically a criminal law matter and such limits may be designed to suppress

[17] *Ibid*, at para 79,
[18] *Ibid*, at paras 104-106 and 114-121.
[19] *Constitution Act, 1867*, section 91(27).
[20] *Carter*, *supra* note 1,at paras 49-53.

assisted suicide as a "socially undesirable" practice.[21] Since the provinces cannot fill "gaps" in criminal law,[22] Parliament cannot merely put in place a simple exception to the general prohibition on assisted suicide. The SCC deliberately did not dictate the conditions and safeguards necessary to ensure legalizing assisted suicide will not result in vulnerable persons being pressured to end their lives. Parliament must do so. Provinces cannot.

Even if the provinces did have jurisdiction to enact strict conditions and safeguards, some might not do so and assisted-death tourism between provinces could result. Having conditions, oversight, and reporting requirements differ from province to province is clearly undesirable.

Even if assisted suicide is also considered a health-related matter, health is a subject of concurrent jurisdiction, meaning that both levels of government (federal and provincial) can enact legislation in relation to it. The criminal law power authorizes federal laws that punish or regulate conduct that is dangerous to health or that raises issues of public morality. Examples include federal laws regulating narcotics, tobacco, and other harmful products, and in the past, federal regulation of abortion. Key statutes are the *Food and Drugs Act*, the *Controlled Drugs and Substances Act* and the *Criminal Code*.

Parliament's criminal law power allows Parliament to enact a limited exception to a general criminal law prohibition, along with a comprehensive regulatory regime to give effect to such an exception. General prohibitions with limited and conditional exceptions or defences are a common feature of criminal law.[23] The fact that Parliament introduced an exception allowing abortion for health reasons in 1969—an exception which required a certificate of approval from a panel of three doctors in provincially approved hospitals—did not mean that Parliament gave up or narrowed its jurisdiction to regulate abortion, as affirmed repeatedly by the SCC, even after the 1969 law was found to violate the *Charter*.[24]

[21] *R v Morgentaler*, [1993] 3 SCR 463.
[22] *Ibid*, at 498.
[23] *RJR-Macdonald*, [1995] 3 SCR 199, at para 53.
[24] The jurisdictional validity of the criminal law scheme permitting abortion only where approved by a therapeutic abortion committee for health reasons was upheld in *Morgentaler v The Queen* (1975), [1976] 3 SCR 616, at 627. Parliament's jurisdiction over the matter of abortion was reaffirmed by the SCC in *R v Morgentaler*, [1993] 3 SCR 463; it was mentioned more recently by the SCC again in *Canada v PHS Community Services Society*, 2011 SCC 44, at para 68 [*PHS*].

Parliament also has authority to create administrative and enforcement schemes under its criminal law power to give effect to an exception to a general prohibition. The creation of such a scheme may impact matters falling under provincial jurisdiction, but provided that Parliament enacts an integrated legislative scheme for a criminal law purpose, incidental impacts on matters of provincial jurisdiction are permissible.[25] Just because a federal law has the incidental effect of regulating provincial health institutions does not mean that it is constitutionally invalid.[26]

Provincially regulated health professionals and health care institutions are subject to criminal law.[27] There is no "core" provincial jurisdiction over health such as to prevent the application of a comprehensive federal regulatory regime to medical professionals or health institutions.[28] Should there be a conflict between legitimately enacted federal and provincial laws, which occurs where compliance with one law makes compliance with the other impossible or where the provincial law frustrates the purpose of the federal law, federal law is paramount.

b) Legalization requires strict limits, scrupulously monitored and enforced

As recognized by all levels of court in *Carter*, assisted suicide (and voluntary euthanasia) is a complex issue. Legalization involves significant risks to society and to individuals, especially persons with disabilities, severe illness, or mental health problems. As the trial judge noted: "This review of the evidence permits no conclusion other than that there are risks inherent in permitting physician-assisted death, and that the utmost care would be needed in designing and managing a system which would allow it, in order to avoid those risks."[29] The SCC acknowledged in *Carter* that Parliament faces a difficult task in addressing physician-assisted suicide because it "involves complex issues of social policy and a number of competing social values" and Parliament must therefore "weigh the risks of a permissive regime with the rights of those who seek assistance in dying."[30]

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[25] See *Morgentaler v The Queen* (1975), *ibid*, at 628; *Firearms* Reference, 2000 SCC 31; *PHS*, *ibid*, at paras 50-52.
[26] *PHS*, para 51.
[27] See *PHS*, para 72.
[28] *PHS*, para 69; *Carter*, para 53.
[29] *Carter v Canada*, 2012 BCSC 886, at para 854.
[30] *Supra* note 1, at para 98.

The SCC stated that "Parliament must be given the opportunity to craft an appropriate remedy". The SCC refused to implement a remedy itself because "Complex regulatory regimes are better created by Parliament than by the courts."[31] A complex regime is *necessary* in order to substantially minimize the risk of abuse and error if assisted suicide or voluntary euthanasia is permitted at all. Such a regime must be fully in place before assisted suicide or voluntary euthanasia is permitted at all.

Short of complete prohibition, Parliament must enact all necessary measures to ensure that consent is always properly obtained and recorded and that assisted suicide only takes place in strictly limited circumstances. The SCC decided that the existing complete prohibition on assisted suicide violated the section 7 rights of "Ms. Taylor and of persons in her position".[32] 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."[33] 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. Therefore, any physician who provides aid in dying in different factual circumstances may risk liability.

Short of a complete prohibition, Parliament should make an exception only where, and *Carter* only requires an exception to the existing prohibition only where the patient:

- is incapable of taking their own life;
- is a competent, fully informed adult;[34]
- acts voluntarily, without coercion, duress or ambivalence;
- is grievously and irremediably ill; and

[31] *Ibid*, at para 125.
[32] *Ibid*, at para 56.
[33] *Ibid*, at para 127.
[34] In order for consent to be informed, the patient must first have had access to fully adequate palliative care. Many patients who ask for euthanasia change their minds when given good palliative care: see M.C. Jansen-Van Der Weide, B.D. Onwuteaka-Philipsen, and G. Van Der Wal, "Requests for euthanasia and physician-assisted suicide and the availability and application of palliative options", *Palliative and Supportive Care* (2006), 4, 399–406; see also Dr. Harvey Max Chochinov, "Dignity Therapy: Final Words for Final Days", Oxford University Press, 2012, at pp 44-46, highlighting the positive impact of a form of palliative care on terminally ill patients. Currently, approximately only 16-30% of Canadians who need palliative care have access to it, which is appalling—see the Parliamentary Committee on Palliative Care and Compassionate Care report, "Not to be Forgotten: Care of Vulnerable Canadians" at p. 22 (November 2011, online: <http://pcpcc-cpspsc.com/wp-content/uploads/2011/11/ReportEN.pdf>.

- is experiencing enduring and intolerable pain caused by a grievous and irremediable medical condition (not including depression or psychiatric illness);

In order to ensure that the conditions listed above are complied with, the law must only permit the provision of "aid in dying" where:

- there is in place an audio visual record of the informed consent that includes the diagnosis and prognosis of the patient, together with a detailed description of the palliative care alternatives available to the patient to reduce pain;
- there is in place a written medical opinion signed by two physicians (one of whom must be the personal primary care provider for the patient) declaring that physician assistance in a patient's suicide is clearly consistent with the patient's wishes and best interests and provided in order to relieve suffering;
- a judge reviews the informed consent process and issues a warrant declaring that the strict limits and scrupulous monitoring required by Parliament have been followed;
- adequate notice of the patient's judicial application is given to immediate family members;
- the application to the judge is made exclusively by the patient (no power of attorney and no advance directive permitted)[35];
- the activation of the physician-assisted suicide is dependent upon a positive indication from the patient;
- the judicial review has allowed the judge opportunity to inquire regarding cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice, ambivalence and misdiagnosis of the patient;
- the judicial review has confirmed that the patient is not a minor, is not suffering from a psychiatric disorder and is not simply experiencing a minor medical condition; and
- no physician or health care facility has been required to refer a patient, or otherwise participate in providing assistance, for physician-assisted suicide against the conscience of the physician or of the facility.

Participation in assisted suicide by physicians must be entirely voluntary. And for those who choose to participate, there must be adequate oversight of their activities. This is primarily a legal issue,

[35] The prohibition on assisted suicide applies unless the person "clearly consents to the termination of life"—*Carter*, *supra* note 1, at para 27. Stated as it is in the present tense, this statement requires contemporaneous consent from the person seeking assisted suicide, therefore ruling out advance directives and power of attorney. This was the finding of the British Columbia Court of Appeal in *Bentley v. Maplewood Care Society* , 2015 BCCA 91, where the court concluded that a patient`s decision to accept or refuse food and water at her care facility could only be made in the "here and now", not through an advance directive:

> It should come as no surprise that a court of law will be assiduous in seeking to ascertain and give effect to the wishes of the patient in the 'here and now', even in the face of prior directives, whether clear or not. This is consistent with the principle of patient autonomy that is also reflected in the statutes referred to earlier (see especially s. 19.8 of the HCCCFA Act), and in many judicial decisions, including *Carter v. Canada (Attorney General)* 2015 SCC 5 (CanLII), where the Court emphasized that when assisted suicide is legalized, it must be conditional on the "clear consent" of the patient. (para. 127, emphasis added).

and so physicians who choose to participate should be subject to judicial oversight. A judge will be best able to referee the boundary between homicide or illegal assisted suicide and permissible assisted suicide.

Although it appears to be a proposal for a temporary remedy, Justice McLachlin (as she then was) once proposed, in her dissenting opinion in *Rodriguez v British Columbia (AG)*:

> [The relevant *Criminal Code*] provisions may be supplemented, by way of a remedy on this appeal, by a further stipulation requiring court orders to permit the assistance of suicide in a particular case. The judge must be satisfied that the consent is freely given with a full appreciation of all the circumstances. This will ensure that only those who truly desire to bring their lives to an end obtain assistance.[36]

The presence or absence of consent may determine whether an action is a crime. When it comes to homicide and assisted suicide, however, the law makes consent irrelevant. The rule that nobody is entitled to consent to his or her own death is stated in section 14 of the *Criminal Code*, which was partially invalidated by the SCC in *Carter*. The rule upholds the inviolability of life. It also has important evidentiary implications. Any victim of homicide, euthanasia (technically a form of homicide), or assisted suicide is, of course, dead, and thus not available to testify as to whether or not he or she consented to have death inflicted on him or her. Thankfully for the prosecutor, consent has always been irrelevant, at least until the *Carter* ruling. If Parliament is willing to permit assisted suicide in any circumstances, strict procedures for reliably obtaining and recording a patient's consent must be mandated and enforced.

CLF also recommends that Parliament consider allowing assisted suicide only in federally approved facilities, which should not include hospitals. Assisted suicide and euthanasia are not care services and they should not be provided in health care institutions, particularly hospitals. These are places where people go to receive healing and life-prolonging care, not to deliberately end their lives. The psychological impact on patients and indeed the broader cultural compact of having deliberately induced death provided in the same facilities as health care is a social harm that Parliament ought to prevent. Restricting the facilities in which "aid in dying" is permitted also promotes effective government oversight and patient safety.

[36] *Supra* note 7, at 627.

4. Parliament must protect physicians and other health care workers from being pressured to participate

The SCC offered the following brief remarks on physicians' freedom of conscience in *Carter*:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in Morgentaler — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.[37]

It would be shocking if voluntary euthanasia and assisted suicide went from being a serious crime in Canada one year to being a publicly funded service that physicians have a duty to provide or facilitate the next year as a result of a judicial declaration that "simply renders the criminal prohibition invalid" in very limited factual and legal circumstances. *Carter* does not create a positive right to receive "aid in dying". Provinces have no obligation to fund it and should not. Provincial governments in Canada have a statutory monopoly on health insurance. In a single-payer system, the single payer should not be funding both health care and assisted suicide or euthanasia. The latter is the decision to deliberately end life and therefore end the need for further care—and the need to fund further care. Public funding of assisted suicide and euthanasia would create perverse incentives. Physicians also have no obligation to provide or facilitate assisted suicide or euthanasia. *Carter* simply determined a (jurisdictionally valid) criminal prohibition to be overbroad under the *Charter*. It did not create a positive right to receive "aid in dying."

a) Is there a conflict of rights?

The rights of patients and physicians only need to be reconciled where they are in conflict. The SCC comments that "the *Charter* rights of patients and physicians will need to be reconciled", but in light of what it says before that—"the declaration simply renders the criminal prohibition invalid"—it is not

[37] *Supra* note 1, at para 131.

clear that there is any conflict of rights. Rendering a criminal prohibition against assisted suicide invalid does not create a positive right to receive it.

Moreover, *Charter* rights exist vis-à-vis the state. Physicians' freedom of conscience and religion in section 2(a) of the *Charter* shields them from being required by the state to participate in an activity that violates their conscience or religion. In the context of assisted suicide and voluntary euthanasia, patients' rights stem from section 7 of the *Charter*. The section 7 right to life was engaged in *Carter* because the prohibition on assisted suicide might cause some people to take their own lives "prematurely" for fear that they would be incapable of doing so later.[38] The rights to liberty and security of the person were engaged because the law interfered with "fundamental personal choices" and "control over one's bodily integrity".[39] The fact that life, liberty, or security of the person is engaged, however, does not mean section 7 is violated. It is violated only if the state interference with life, liberty, or security of the person is not in accordance with the principles of fundamental justice.

Section 7 of the *Charter* does not provide patients a positive right to receive health care or any other service. In order to give effect to such a positive right, the state might have to force others to provide the service, thereby violating their rights. If nobody is willing to help me die, I cannot demand that the state force someone else to help me die. If a physician refuses to provide or facilitate "aid in dying", a patient cannot complain that the physician is violating his or her *Charter* rights. Patients do not have *Charter* rights vis-à-vis physicians. Physicians are not agents of the state and are not bound by the *Charter*.[40] Physicians' section 2(a) rights and patients' section 7 rights are therefore not pitted against each other directly. These rights exist vis-à-vis the state. It is the state that must justify interfering with either.

b) Is requiring physician participation justified?

Section 2(a) of the *Charter* protects the "fundamental freedom" of conscience and religion. Any violation section 2(a) must be justified under section 1 of the *Charter*—that is, it must be the result of "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

[38] *Ibid*, at paras 57-58.
[39] *Ibid*, at para 64.
[40] See *R. v. McDougall*, 2013 SKQB 358, at paras 88-89; *R v. Hart*, 2014 SKPC 42, at paras 28-33.

In order to justify a requirement that physicians participate in assisted suicide (even indirectly by providing referrals), the state (including medical regulatory bodies) must demonstrate a pressing and substantive objective. The objective of requiring participation or facilitation would be to ensure that patients receive the service they need or desire, but it is doubtful whether this is a pressing and substantive objective capable of limiting physicians' s. 2(a) right. It is a policy objective, not a constitutional imperative. The objective of a law requiring physician participation or facilitation of "aid in dying" cannot be the fulfillment of patients' section 7 rights, since section 7 does bestow positive rights to receive a service from the state, let alone from private citizens, which physicians are.

Moreover, even if it is a pressing and substantive objective, the means to accomplish it must be rationally connected to the objective and must minimally impair the right in question. However, there is no legal precedent or evidence to suggest, nor any reason to think that a physician clearly informing a patient of his or her objection to assisted suicide, so that the patient may seek this service elsewhere, would fall below the standard of care owed by physicians to their patients or prevent the patient from finding an assisted suicide provider. Assisted suicide is not a response to an emergency, such that fast and effective referral to a known provider would be necessary.

As a result of the evolution of the patient-physician relationship, it is now widely agreed that a physician should not be allowed to act according to conscience if it means coercing a patient to accept treatment. Neither should patients be allowed to insist on being provided or at least referred for treatment even if it means coercing the physician to do something she finds morally objectionable.

c) How can Parliament protect physicians' freedom of conscience?

Maintaining a complete prohibition on assisted suicide and euthanasia is the clearest and best way to protect physicians' freedom of conscience. Many physicians are opposed to these practices and are concerned about the implications that legalization will have for them. As the Canadian Medical Association recognized in its 2007 policy document entitled *Euthanasia and Assisted Suicide*:

> Euthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. For the medical profession to support such a change and subsequently participate in these practices, a fundamental reconsideration of traditional medical ethics would be required.

Short of maintaining a complete prohibition, Parliament should make it an offence to pressure any person to participate in assisted suicide or euthanasia, as a component of comprehensive legislation on assisted suicide and euthanasia enacted under its criminal law power. Existing *Criminal Code* provisions, including the offences of assault, exploitation, and criminal harassment, would not apply where a person is pressured to participate or else lose their job, for example.[41]

Pressuring a person to participate in assisted suicide is not merely a matter of discrimination and failure to accommodate, which arises quite commonly in an employment context. Participating in the deliberate inducement of death on another person remains an affront to medical ethics and to the longstanding legal principle of the inviolability of life. It is, as Justice Sopinka put in in 1993, inherently morally wrong.[42] While *Carter* found that the objective of the law was not to enforce the inviolability of life, neither did it overturn the finding in *Rodriguez* about the inherently immoral nature of deliberately participating in actively causing another person's death.

Parliament may decide to permit two parties—recipient and provider—to consent to this intrinsically wrong act. In principle, such a law would allow autonomy to trump the inviolability of life, at least in certain circumstances. However, it would violate a person's autonomy and moral integrity to be pressured into participating in assisted suicide or euthanasia, a violation with such profound implications as to justify the exercise of Parliament's criminal law power to prevent it.[43] Again, this is no ordinary matter of reasonable accommodation. Consider that counselling someone to commit suicide remains a crime under section 241(a) of the *Criminal Code*, whereas advising someone to receive chemotherapy or palliative care is no crime and never has been. Canadian law continues to recognize the difference between

[41] Section 265, 279.04, and 264 of the *Criminal Code of Canada*, respectively.
[42] *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519, at 601.
[43] Criminal law consists of a prohibition with a penalty, for a criminal law purpose such as public peace, safety, order, security, morality, health, environmental protection, or some similar purpose. See *Reference re Validity of Section 5 (a) Dairy Industry Act*, [1949] SCR 1, at 49; see also *AHRA Reference*, 2010 SCC 61, at para 1 and 43.

health care and suicide or euthanasia, and whereas the degree of participation required of a health care professional in providing health care may be a matter of balancing professional duties with reasonable accommodation, pressuring someone to participate in the latter is such a severe affront to human dignity that it ought to be an offence.

All of which is respectfully submitted,

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Appendix A

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October 19, 2015

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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

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