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November 15, 2015

Lynne Arnason
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College of Physicians and Surgeons of Manitoba

Sent by e-mail to: pad@cpsm.mb.ca

Re: CPSM Draft Statement on Physician Assisted Dying

Dear Ms. Arnason,

The College of Physicians and Surgeons of Manitoba ("CPSM") has invited feedback concerning its new draft statement on Physician Assisted Dying ("PAD"). Specifically, the CPSM has invited feedback on what guidance it should provide to physicians and patients that is consistent with the Supreme Court of Canada's ("SCC") decision in *Carter v. Canada*[1].

Christian Legal Fellowship ("CLF") 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. 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 both physicians and patients, and to identify a number of human rights concerns engaged as a result of the proposed introduction of physician-assisted suicide.

OVERVIEW

CLF recognizes that the CPSM's draft statement is a good faith effort on the part of the CPSM to address a very serious matter. The draft statement contains several thoughtful provisions and in particular, CLF applauds the CPSM for stating explicitly that physicians will not be required to provide or refer for "physician-assisted dying" (PAD).

[1] 2015 SCC 5.

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However, from a legal perspective, the draft statement is premature, outside the CPSM's jurisdiction, overlooks critical nuances with respect to the scope of the invalidation of the criminal prohibition on assisted suicide, and appears to be based on the false premise that medical colleges and their members have a positive obligation to provide or facilitate access to PAD. For the reasons set out in this submission, the CPSM should wait for Parliament to set out the precise parameters of any exception to the criminal prohibition on assisted suicide. Moreover, on its own, the draft statement would fail to adequately protect patients, particularly vulnerable patients, for which a complex regime containing strict safeguards that are scrupulously monitored and enforced is necessary and beyond the CPSM's capacity to establish.

CPSM Draft Statement is outside its jurisdiction and risks misleading physicians and patients on the law

In the absence of a legislative regime designed by Parliament, the CPSM must not attempt to instruct its members on how to interpret and apply the SCC's declaration in *Carter v Canada*. Without clear standards enacted by Parliament, the CPSM risks misinterpreting the SCC's decision in *Carter* and its members could face criminal liability. The draft statement overlooks the nuances of what *Carter* in fact decided and the extent to which the criminal prohibition on assisted suicide will be void.

Outside CPSM's jurisdiction

The CPSM assumes, as stated in its online survey, that "The College of Physicians and Surgeons of Manitoba (CPSM) is bound by the Supreme Court ruling, so the issue is not whether the CPSM should support or oppose physician assisted dying."[2] With respect, this assumption indicates some misunderstanding on the part of the CPSM about the nature of the *Carter v Canada* decision and the respective jurisdictions of Parliament, provincial legislatures, and medical regulatory authorities. Nothing in the *Carter* decision requires the CPSM to ensure that physician-assisted suicide is provided by its members or even made available at all. 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 SCC affirmed (in paragraphs 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. Rather, the ruling "simply renders the criminal prohibition invalid"[3] in the factual circumstances of the *Carter* case.[4]

CPSM's jurisdiction is derived from provincial statute and from no other source. Provincial law does not give the CPSM jurisdiction to determine when and under what circumstances assisted suicide falls with a judicially declared exception to the *Criminal Code of Canada*. The absence of federal legislation to date does not and cannot expand the jurisdiction of the provinces or, by extension, provincial regulatory bodies such as the CPSS.[5]

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[2] CPSM. "Consultation on Draft Statement: Physician Assisted Dying", online, <http://www.nrg-surveys.com/Survey/intweb.dll>.

[3] *Carter*, *supra* note 1, at para 132.

[4] The SCC limits the scope of its declaration of the prohibition's invalidity explicitly in para 127, *ibid*: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought."

[5] 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

The existing prohibition on assisted suicide in the *Criminal Code* was not upheld under section 1 of the *Charter* only because the SCC was persuaded that "a properly administered regulatory regime"[6] that "imposes strict limits that are scrupulously monitored and enforced"[7] 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."[8] With respect, the necessary regime for implementing the *Carter* decision, properly understood, is beyond the jurisdiction and capacity of the CPSM or any other medical regulatory authority.

Potential for misunderstanding on the law

CPSM's draft statement incorporates the SCC's statement in *Carter* that the prohibition is void where a patient clearly consents and has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the patient, but it extracts this from its proper context. It thereby risks misleading its readers with respect to the circumstances in which the criminal prohibition on assisted suicide is void. *Carter* is a judicial ruling based on certain facts. A particular line from a judicial ruling cannot be read as if it forms an amendment to the *Criminal Code*. Indeed, even a particular provision of a statute must be read in the context of a whole statute in order to be interpreted correctly.

In *Carter*, the SCC interprets and applies section 7 of the *Charter* to the factual circumstances of Ms. Taylor. Ms. Taylor, like Ms. Rodriguez, the plaintiff in the 1993 case[9], had a fatal neurodegenerative disease called amyotrophic lateral sclerosis or ALS. This disease progressively deteriorates one's muscles until one loses the ability to walk, chew, swallow, speak and, eventually, breathe. Ms. Taylor was joined in her claim by Lee Carter, who did not have an illness or disability,[10] and by Dr. Shoichet, a physician who expressed willingness to participate in assisted suicide if it were legalized and by the British Columbia Civil Liberties Association. The only claimant with an illness in *Carter* was Ms. Taylor, and the SCC was explicit in stating that its *Charter* analysis applies to her factual situation only. The degree of debilitation and suffering caused by ALS were the factual findings on which the SCC's finding of interference with the right to life, liberty, and security of the person were based.

Introducing its section 7 analysis, the SCC states, "For the reasons below, we conclude that the prohibition on physician-assisted dying infringes the right to life, liberty and security of *Ms. Taylor and of persons in her position* […]."[11] The Court repeatedly refers to Ms. Taylor and people like her throughout its section 7 analysis.[12] Concluding its section 7 analysis, the SCC states, "To the extent that impugned laws deny the s. 7 rights of people like Ms. Taylor they are void by the operation of s. 52 of the *Constitution Act, 1867*."[13] The Court further clarifies the scope of its ruling by saying, in para 127, "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other

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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).

[6] *Carter*, *supra* note 1, at para 3.

[7] *Ibid*, at para 27.

[8] *Ibid*, at para 125.

[9] *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519.

[10] Before *Carter*, Lee Carter had helped her mother, Kathleen Carter, travel to Switzerland where her mother received assistance in ending her life from an assisted suicide clinic.

[11] *Carter*, *supra* note 1, at para 56 (emphasis added).

[12] *Carter*, *supra* note 1, at paras 56, 57, 65, 66, 126, and 127.

[13] *Ibid*, at para 126.

situations where physician-assisted dying may be sought."[14] If a person is suffering from a grievous and irremediable condition but remains able-bodied, for example, such a person would not face the complete loss of control over his body that someone is Ms. Taylor's position would. This would be one of the "other situations where physician-assisted dying may be sought", to which the prohibition would still apply. The physical debilitation and loss of control over their body caused by ALS was the reason that each of the rights protected by section 7 of the *Charter*—life, liberty, and security of the person—were found to be infringed by the prohibition on assisted suicide.

The SCC's statement about a "competent adult" who "clearly consents" cannot be properly understood outside of this context. Moreover, even in its proper context, the SCC's declaration of invalidity in *Carter*, while circumscribed, remains imprecise and unclear and should not be read—or presented to physicians and/or their patients—as an amendment to the criminal prohibition on assisted suicide. It was not intended to be. The parameters in which assisted suicide or voluntary euthanasia will no longer be a crime must—and have yet to be—established by Parliament.

Policy Could Expose CPSM and its Members to Liability

The CPSM should urge its members not to participate in assisted suicide until appropriate legislation is enacted. 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 CPSM 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 CPSM will signal to its members that they may participate in physician-assisted dying without facing legal risks. But the CPSM 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, to reiterate, the CPSM should instruct members not to participate in assisted suicide until appropriate legislation is enacted.

The CPSM is not obligated by the *Carter* decision to create a policy on physician-assisted death or to facilitate access to it. And, of course, individual members of the CPSM have no obligation to participate. Physicians are not agents of the state and are not bound by the *Charter*. While the CPSM may not prohibit its members from participating in assisted suicide (to the extent that it may be permitted by law), since it lacks jurisdiction to do so, it can and should discourage them from participating absent clear legal standards set out in legislation. The circumstances in which PAD is permissible 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 remainder of CLF's submissions focus on addressing the three specific questions raised by the CPSM for public input in its online consultation.

1. **Do you agree that the requirements would adequately protect patients seeking physician assisted dying? What additional protections should be put in place?**

No.

First, the draft statement's elaboration of "grievous and irremediable medical condition" as a criterion of eligibility for PAD is overly broad and subjective. The draft statement requires an "illness, disease or

[14] *Ibid*, at para 127.

disability" that causes "severe physical or psychological pain and suffering." With respect, *Carter* does not invalidate the criminal prohibition on assisted suicide with respect to those who are suffering psychologically but not physically. Psychiatric conditions and mental illnesses, including major depression, would fall within "other situations where physician-assisted dying may be sought"[15]—situations to which the *Carter* ruling does *not* apply.[16]

Second, in *Carter*, the SCC concluded that 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. Not only is such a regime desirable, it is *necessary* to minimize error and abuse. With respect, the requirements contained in the CPSM draft statement are inadequate, including the following:

- The statement requires that a physician involved in providing PAD be "qualified by specialty, training or experience to meet the specific requirements of this Statement which apply to that physician's role". The specialty, training, or experience, however, is not specified. Formal qualification following training should be required for any physician to be involved.

- The presence of coercion or undue influence is extremely difficult to detect. A 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, the presence or absence of which should be subject to a detailed evidentiary inquiry in a court of law. Simply meeting with the patient may be inadequate. 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, which would likely require the involvement of persons outside of the medical profession.

- A particularly glaring problem in the draft statement is that a physician must only have "reasonable grounds" that the statement's requirements have been followed. "Reasonable grounds" is a grossly insufficient standard. In light of the magnitude of the issues involved in this process—literally, life and (deliberately induced) death—the physician should be sure, beyond a reasonable doubt, that all of the statement's requirements have been met. However, even following this draft statement perfectly would not guarantee the physician's protection against criminal or civil liability.

Even if the CPSM 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 statement says nothing about how its proposed safeguards will be monitored (besides documentation requirements) and enforced.

2. **Do you agree that the [draft statement] would adequately respect the values of both patients and physicians?**

The CPSM is right to not require any physician to provide, participate in, or refer for PAD. The draft statement is commendable on this point, as it shows great respect for freedom of conscience and religion, one of the "fundamental freedoms" protected by the *Charter*. It is also fair to require that physicians not actively impede patients' access by, for example, deception or withholding medical records that are rightly the property of the patient.

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[15] *Ibid*.

[16] In fact, although the SCC did not comment on this specific point, the trial judge in *Carter* precluded the availability of physician-assisted suicide to patients who are clinically depressed: *Carter v Canada (Attorney General)*, 2012 BCSC 886, at para. 1388).

However, the statement that physicians must not “impose their moral or religious beliefs about physician assisted dying on patients” is both unclear and unnecessary. It is unclear what “impos[ing] their moral or religious beliefs” means. It is also unclear what, if anything, it adds to the requirement that a physician “must not impede patients’ access to physician assisted dying” and the requirements that, upon receiving a request for PAD, objecting physicians disclose their objection, provide access to information about PAD, continue to provide care, make available the patient’s health information, and provide a copy of the CPSM statement.

It remains a crime, under section 241(a) of the *Criminal Code*, to counsel someone to commit suicide. Physicians therefore must never advise a patient to choose or consider suicide. Physicians ought rather to counsel *against* it. Does counseling a person against receiving PAD amount to imposing one’s moral beliefs on the patient?

The College of Physicians and Surgeons of Ontario’s policy, “Planning for and Providing Quality End-of-Life Care”[17], emphasizes the need to examine the motivation for a request for PAD and to steer the patient towards other options:

> Because [patients’ requests to hasten death] may be motivated by an issue that can be treated or addressed, physicians must be prepared to engage patients in a discussion to seek to understand the motivation for their expression and to resolve any underlying issues that can be treated or otherwise addressed. This may include providing more effective treatment, improving pain management strategies, providing or referring the patient for psychological counselling, seeking specialist support, and involving other professionals in the patient’s care (e.g., chaplaincy support, social workers, grief counselling, etc.).[18]

Doubtless, most physicians will feel morally obligated to encourage the patient to explore other options besides PAD; all physicians ought to do so. The CPSM’s draft statement should offer guidance to physicians on how to steer patients away from PAD where possible. The current statement about not imposing one’s moral or religious beliefs may have chilling effect that does not serve the best interest of patients or respect the freedom of conscience of physicians.

Another potential violation of freedom of conscience lies in the requirement that physicians “provide the patient with timely access to another member or resource that will provide accurate information about physician assisted dying”. The accompanying footnote in the draft statement says that resources “may include but are not limited to other health care providers, counsellors and publicly available resources for [PAD].” The expectations here are unclear, but a physician should not be required to refer a patient to a resource, whether a person or a document, that in the physician’s view might inappropriately pressure and/or promote PAD to the patient. Provided the resource accurately states the circumstances in which PAD is legally available and the process necessary to obtain it, physicians should be free to refer patients to resources of their choosing.

3. Do you agree that the [draft statement’s] requirements would adequately document both patient wishes and assessment by the physician?

No.

In order to adequately protect patients, every precaution must be taken to ensure that any person who requests physician-assisted suicide is acting with free and informed consent.[19]

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[17] Policy Number #4-15, September 10, 2015, online: <http://www.cpso.on.ca/Policies-Publications/Policy/Planning-for-Providing-Quality-End-of-Life-Care>.

[18] *Ibid*, at part 7.1.

[19] 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

Free and informed consent is the dividing line between criminal and non-criminal activity. Before *Carter*, consent was always irrelevant when it came to homicide and assisted suicide. The Crown would not have to prove absence of consent as part of the offence. Unlike other offences, homicide and assisted suicide kill the primary witness. Once the person is dead, it becomes impossible, without the reliable advance recording of consent, to determine whether informed consent was truly given. The CPSM's requirements that the physician certify in writing that he or she is satisfied "on reasonable grounds" that the requirements for PAD have been met and that the patient fill out a form are, without more, grossly inadequate.

CLF has recommended to the (federal) External Panel on External Panel on Options for a Legislative Response that Parliament require a judge to review the informed consent process and issues a warrant declaring that the strict limits and scrupulous monitoring required by Parliament have been followed. The CPSM would serve patients and its member physicians well by pushing for such oversight. Again, the circumstances in which PAD is permissible is a *legal* issue.

4. [Should] the physician who administers or provides the lethal medication to the patient be readily available to care for the patient at the time the medication is administered by the physician or taken by the patient until the patient is declared dead by a physician?

In light of section 245 of the *Criminal Code*, which remains valid and in force, it may be illegal for physicians to administer a lethal medication. The draft statement defines physician-assisted dying as "medical intervention that involves providing or administering medication that intentionally causes the patient's death at the patient's request." While the SCC uses a very similar phrase to define PAD in paragraph 40 of its ruling, this is not an authoritative legal definition by the Court. Rather, it was merely a recitation of the appellants' understanding of what physician-assisted dying means. 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*. 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 CPSM should urge its members to await a legislative response to the *Carter* decision from Parliament before participating in the suicide of any patient.

5. [Should] physician assisted dying only take place in health care institutions?

This a matter that should be decided by legislation, not CPSM policy.

PAD should be allowed to occur only in a government-approved facility that is licensed to provide it. This is necessary in order to ensure that all necessary safeguards are in place and the necessary procedures followed when PAD is administered. Protocols must be established for such facilities to follow. Only qualified people should be allowed to be present when PAD is administered. All qualified witnesses should be properly identified.

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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, highlighting the positive impact of a form of palliative care on terminally ill patients' will to live. 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> .

No health care facility should be required to obtain such a license or to refer a patient for PAD or otherwise participate in providing PAD.

6. [Should there] be a mobile unit available to patients who wish to receive physician assisted dying in their home?

Absolutely not. Minimizing the risk of error and abuse requires "strict conditions" that are "scrupulously monitored and enforced," which cannot be achieved where PAD is being provided in patient's homes.

RECOMMENDATIONS

The draft statement contains some positive elements related to the protection of conscience rights—namely, the fact that it does not require provision of PAD or referral—which ought to be implemented. However, overall, in light of the many legal issues and areas of potential liability outlined above, CLF submits that the existing draft statement on Physician Assisted Death is inappropriate at this time, unworkable, and most importantly, outside of the CPSM's jurisdiction. CLF urges the CPSM to abandon this draft statement 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 CPSM believes would be appropriate.

Thank you for your consideration of our submissions.

Sincerely,

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