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January 6, 2015

Dr. Ed Schollenberg, Registrar
College of Physicians and Surgeons of New Brunswick
One Hampton Road, Suite 300
Rothesay, NB E2E 5K8

Sent via e-mail to info@cpsnb.org

Re: CPSNB Guidelines – Assistance in Dying

Dear Dr. Schollenberg,

We write this letter on behalf of Christian Legal Fellowship ("CLF") in response to the College of Physicians and Surgeons of New Brunswick's ("CPSNB") new Guidelines on Assistance in Dying ("Guidelines").

Since the CPSNB has invited comment on its views expressed in the Guidelines, and has described them as "preliminary" and a "work in progress",[1] we take this opportunity to provide feedback as well as to explain the legal implications of physician participation in assisted suicide or euthanasia. This submission is provided as a source of clarification and information to the CPSNB as part of its policy review process and is not intended to constitute or substitute legal advice. CLF recognizes that the Guidelines are a good faith effort on the part of the CPSNB to address a very serious matter. However, CLF is concerned that the Guidelines risk misleading physicians and others with respect to the criminal law on assisted suicide and euthanasia. A legislative response from Parliament is both anticipated by the Supreme Court of Canada (SCC) in *Carter* and is necessary before physicians participate in assisted suicide or euthanasia.

Christian Legal Fellowship

CLF is a national charitable association of over 600 lawyers, law students, professors, and others who support its work. CLF 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.

[1] CPSNB, December 2015 Bulletin, online: <http://www.cpsnb.org/english/Bulletins/December2015.htm>.

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CLF was an intervener in the *Carter v Canada (Attorney General)*[2] case at all levels of court including the Supreme Court of Canada. CLF also intervened in both levels of court in *Québec (Procureure générale) c. D'Amico*[3], a case involving a challenge to parts of Quebec's *An Act Respecting End-of-Life Care*[4] purporting to authorize physician-assisted dying. CLF participated, by invitation, in the consultations of the federal External Panel on Options for a Legislative Response to *Carter v Canada*. CLF has also participated in the consultations of the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying, and those of the medical Colleges of Saskatchewan, Manitoba, and Ontario on this issue.

THE CPSNB GUIDELINES

The CPSNB's Guidelines do not mention that criminal prohibitions on assisted suicide and euthanasia (homicide) remain in full force and effect at least until February 6, 2016, and possibly longer if the SCC grants the federal government's request for a 6-month extension of the suspension of the declaration of invalidity in *Carter*. Physicians or members of the public reading these guidelines on the CPSNB's website could be misled into believing that "assistance in dying" is currently legal and its Guidelines currently in effect, which is surely not the CPSNB's intent.

Moreover, even after the *Carter* ruling takes effect, the CPSNB must not, in the absence of a legislative regime from Parliament, attempt to instruct its members on how to interpret and apply the SCC's ruling in *Carter*. Without clear standards enacted by Parliament, the CPSNB risks misinterpreting the *Carter* ruling, which partially invalidated certain *criminal* law provisions. With respect, the Guidelines overlook the nuances of what *Carter* in fact decided and the extent to which the criminal prohibition on assisted suicide will be void when *Carter* comes into effect.

Assisted suicide and euthanasia – including by physicians – remain criminal law matters

Under Canada's Constitution, he line between criminal and non-criminal participation in a person's suicide or euthanasia, including by physicians, must be drawn by Parliament, not medical regulatory bodies such as the CPSNB. While the SCC made a declaration that the laws in question were void "insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition",[5] it left up to Parliament the conditions, restrictions, and legal standards dividing criminal from non-criminal assisted suicide or euthanasia.[6]

In *Carter*, the SCC affirmed that Parliament has authority to legislate with respect to assisted suicide under the *Constitution Act, 1867*.[7] 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

[2] 2015 SCC 5 [*Carter*].
[3] 2015 QCCA 2138.
[4] RSQ c S-32.0001.
[5] *Carter*, *supra* note 2, at para 127.
[6] *Ibid*, at para 125.
[7] *Ibid*, at paras 49-53.

be governed by medical regulatory authorities. Rather, the ruling "simply renders the criminal prohibition invalid"[8] as the prohibition applies to the factual circumstances of the *Carter* case.[9]

The existing prohibition on assisted suicide in the *Criminal Code* (section 241(b)) was not upheld under section 1 of the *Charter* only because the SCC was persuaded that "a properly administered regulatory regime"[10] that "imposes strict limits that are scrupulously monitored and enforced"[11] 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."[12] With respect, the necessary regime for implementing the *Carter* decision, properly understood, is beyond the jurisdiction and capacity of the CPSNB or any other medical regulatory authority.

CPSNB's authority is derived solely from provincial statutes and regulations. Provincial law does not give the CPSNB authority to determine when and under what circumstances assisted suicide falls within a judicially declared exception to the *Criminal Code*. The absence of federal legislation to date does not and cannot expand the jurisdiction of the provinces or, by extension, regulatory bodies such as the CPSNB.

Criminal Code provisions beyond those examined in _Carter_ require modification/clarification before physicians may provide "assistance in dying"

Various *Criminal Code* prohibitions relate to euthanasia and assistance in suicide beyond those which were declared partially invalid in *Carter*. These prohibitions were identified in a 1995 report from the Special Senate Committee on Euthanasia and Assisted and include the following sections of the *Criminal Code*: 216 (Duty of Persons Undertaking Acts Dangerous to Life, 217 (Duty of Persons Undertaking Acts), 219 (Criminal Negligence), 220 (Causing Death by Criminal Negligence), 229 (Murder), 241(a) (Counselling Suicide), 245 (Administering Noxious Thing), 264 (Assault), 265 (Assault Causing Bodily Harm), 268 (Aggravated Assault), and 269 (Unlawfully Causing Bodily Harm).[13]

Health care providers in New Brunswick could remain at risk of criminal charges under the above provisions. Assisted suicide or euthanasia should not be permitted to occur in New Brunswick or anywhere in Canada until these matters are adequately addressed by Parliament. The SCC in *Carter* did not intend to deal comprehensively with the criminal law implications of its ruling, but intentionally left that task to Parliament.

The sixth of the CPSNB's Guidelines says that "assistance in dying should not normally be raised first by the physician" unless "presented in a[s] neutral [a] way as possible, as part of a discussion of options available to the patient." Counselling a person to commit suicide remains a crime under section 241(a) of the *Criminal Code*. *Carter* does not turn assisted suicide or euthanasia into a regular health service that should be mentioned as part of a list of "treatment options". Rather, the ruling "simply renders the criminal prohibition invalid"[14]. The CPSNB and its members would do well to await clarification from Parliament as to what will be considered counselling a person to commit suicide.

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[8] *Ibid*, at para 132.

[9] 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."

[10] *Carter*, *supra* note 2, at para 3.

[11] *Ibid*, at para 27.

[12] *Ibid*, at para 125.

[13] The Special Senate Committee on Euthanasia and Assisted Suicide, "Of Life and Death – Final Report" (June 1995), online: <http://www.parl.gc.ca/content/sen/committee/351/euth/rep/lad-tc-e.htm>.

[14] *Carter*, *supra* note 2, at para 132.

Carter legalizes "physician-assisted dying" in narrow circumstances not including depression

The declaration of invalidity in *Carter* was strictly limited in scope. The SCC's *Charter* analysis in *Carter* is bookended by two key statements. First, "For the reasons below, we conclude that the prohibition … infringes the right to life, liberty, and security of Ms. Taylor and of persons in her position".[15] Second, after deciding the *Charter* issues and immediately following the "no force or effect" declaration quoted above, the Court states: "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."[16]

In between those two statements, the Court reviewed and affirmed the trial judge's reasons for concluding that the law deprived Ms. Taylor and persons in her position of the right to life, liberty and security of the person—reasons which depended on the factual circumstances. Ms. Taylor was the only plaintiff in *Carter* with an illness and the SCC conducted its *Charter* analysis in light of the law's impact on Ms. Taylor's rights, not those of the other claimants in the case.[17]

Their right to life was infringed because the law might "force" persons with debilitating diseases to take their own lives while they are still capable of doing so, for fear of being incapable later.[18] Their liberty and security were infringed because the law deprived them of control over their bodily integrity in the context of end-of-life health care decisions.[19] In the Court's view, the principle of patient autonomy on which Ms. Taylor relied in this context is the "same principle that is at work in the cases dealing with the right to refuse consent to medical treatment or to demand that treatment be withdrawn".[20] The Court also considered it contradictory that the law allows people in Ms. Taylor's situation to request palliative sedation or to refuse life-sustaining treatment, while denying them assisted suicide.[21] These are the only "circumstances" in which the declaration in *Carter* about the law's invalidity applies.

There were other good reasons for the Court to expressly limit the scope of its declaration as it did. "Slippery slope" concerns were raised before the Court, including developments in Belgium since *Carter* was heard at the trial level. The Supreme Court, however, ruled that controversial cases arising out of Belgium "would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions."[22]

The Guidelines state, however, as part of the second guideline:

> Depression may be a key element in the suffering of patients with progressive illness; questions may arise regarding the availability of assistance in dying for patients whose main issue is intractable depression. On the one hand, the usual mental health intervention is to admit such patients against their will to protect them. Yet it is not completely impossible that a patient may have been unresponsive to all past interventions and, hence, expects little benefit from future attempts. For that reason, there can be a possibility of assisting such a patient if suffering appears truly severe and there is truly no likelihood of a cure.

The above quotation appears to suggest that a physician may provide assistance in suicide or euthanasia for a person with intractable depression, whether connected to another "progressive illness" or not. However, it

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[15] *Ibid*, at para 56.
[16] *Ibid*, at para 127.
[17] *Ibid*, at para 69, see also paras 30, 32, 42, 56, 65, 66, and 127.
[18] *Ibid*, at paras 30, 57-58.
[19] *Ibid*, at paras 64-69.
[20] *Ibid*, at para 67.
[21] *Ibid*, at para 66.
[22] *Ibid*, at para 111.

is not at all clear that "assistance in dying" provided as a response to depression would be legal even once *Carter* comes into effect. In fact, the Supreme Court in *Carter* explicitly stated that "euthanasia for…persons with psychiatric disorders"[23] was outside of the scope of its reasons and the trial judge in *Carter* specifically precluded physician assisted suicide for those who are clinically depressed.[24]

Of course, Parliament may legislate on this matter before or after *Carter* comes into effect and make it clear whether or not "assistance in dying" is a permissible response to a patient's depression or other psychiatric condition, but until that time the CPSNB should not be issuing Guidelines on the subject.

Accurate reporting and independent oversight is essential

The Guidelines state, under the twelfth guideline:

> In some jurisdictions there is an obligation to report any such deaths to a[n] oversight committee or authority. Such should not apply in New Brunswick. Such creates a high risk of invading the patient's and physician's privacy, especially in a smaller jurisdiction. This does not preclude the collection of anonymized epidemiological data.

With respect, this is plainly out of line with the *Carter* decision. The SCC stated in its ruling:

> [105] … After reviewing the evidence, [the trial judge] concluded that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them:
>
>> … the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced. [trial judgment, para. 883]
>
> [117] … We agree with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards. (emphasis added)

The trial judge found that everywhere assisted suicide or euthanasia has been legalized, there has been error and abuse.[25] Such error and abuse can only be substantially minimized through scrupulous monitoring and enforcement of a detailed system of safeguards. Scrupulous monitoring depends on accurate reporting. Privacy concerns do not require the absence of any oversight authority as legal privacy protections could be applied to such an authority.

The statement that reporting to an oversight should not be required in New Brunswick is a peculiar one in a list of Guidelines presumably directed towards CPSNB members. It is essentially a statement of policy preference that, with respect, is out of line with the *Carter* decision.

Guidelines lack clarity on physicians' constitutional freedom of conscience

The third guideline notes that current CPSNB policy allows physicians to decline to participate, even in a limited way such as a direct referral. This is an important element of the policy and respects physicians' constitutionally protected freedoms of conscience and religion. However, this guideline goes on to point out

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[23] *Supra* note 2, at para 111.

[24] *Carter v. Canada (Attorney General)*, 2012 BCSC 886, at para 1388 [*Carter* trial decision].

[25] See for example the abuses and problems listed in *Carter* trial decision, *ibid*, at paras 472, 475, 484, 502, 554, 556, 561-562, 568, 649, 656, 669, 670, 766-767, 815, 847, and 853.

that referral does not mean the physician necessarily agrees with the patient's choice. With respect, this comes across as patronizing and is an unnecessary addition. Of course a referral does not necessarily indicate agreement, but for some physicians, it does mean participation and moral complicity, just as referring someone to a known drug dealer or contract killer does not necessarily indicate agreement with the actions that follow but does make one morally complicit for knowingly providing such a referral.

Guidelines could expose CPSNB and its members to liability

The CPSNB should urge its members <u>not</u> to participate in assisted suicide or euthanasia until appropriate legislation is enacted. Only federal legislation delineating the scope of permissible assisted suicide or euthanasia can protect physicians from criminal liability. And only a provincial statute can protect physicians from civil liability. Any physician who participates could be subject to a wrongful death lawsuit from any family member or dependent who disagrees with the assessment of the physician.

The Guidelines signal to CPSNB members that they may participate in physician-assisted dying without facing legal risks. But the CPSNB simply cannot guarantee that. Therefore, to put in place such Guidelines in the absence of federal or provincial legislation is to do its members a gross disservice. Instead, to reiterate, the CPSNB should instruct members not to participate until appropriate legislation is enacted.

The CPSNB is not obligated by the *Carter* decision to create policies or guidelines on physician-assisted death or to facilitate access to it. And, of course, individual members of the CPSNB have no obligation to participate. Physicians are not agents of the state and are not bound by the *Charter*. The circumstances in which "assistance in dying" 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.

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. However, in light of the legal issues and areas of potential liability outlined above, CLF submits that the Guidelines are inappropriate at this time, unworkable, and most importantly, seek to resolve legal issues that are outside of the CPSNB's authority. We urge the CPSNB to wait until Parliament legislates on this matter.

CLF would be pleased to provide further assistance in any way the CPSNB believes would be appropriate. Thank you for your consideration of our submissions.

Sincerely,

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Executive Director

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