



CHRISTIAN LEGAL FELLOWSHIP

— Alliance des chrétiens en droit —

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470 Weber St. N., Suite 202, Waterloo, ON, N2L 6J2 • Ph. 519-208-9200 • Fax 519-208-3600 • www.ChristianLegalFellowship.org

January 13, 2016

Dr. Carol Leet, President
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario M5G 2E2

Via email to interimguidance@cpso.on.ca

Re: CPSO Interim Guidance on Physician-Assisted Death

Dear Dr. Leet,

We write this letter on behalf of Christian Legal Fellowship (“CLF”) in response to the College of Physicians and Surgeons of Ontario’s (“CPSO”) consultations regarding its new Interim Guidance on Physician-Assisted Death (“the Document”).

CLF recognizes that the Document is a good faith effort on the part of the CPSO to address a difficult matter. However, CLF is concerned that it risks misleading physicians and others with respect to the law on assisted suicide and euthanasia. A legislative response 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 Council of the United Nations.

CLF was an intervener in the *Carter v Canada (Attorney General)*¹ case at all levels of court and in the recent motion before the Supreme Court of Canada requesting a further suspension of its declaration of invalidity. CLF also intervened in both levels of court in *Québec (Procureure générale) c. D'Amico*², a case involving a

¹ 2015 SCC 5 [*Carter*].

² 2015 QCCA 2138.

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challenge to parts of Quebec’s *An Act Respecting End-of-Life Care*³ 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* and the Provincial/Territorial Expert Advisory Group on Physician-Assisted Dying. CLF also participated in the consultations of the medical Colleges of Saskatchewan, Manitoba, and New Brunswick on this issue.

THE CPSO INTERIM GUIDANCE DOCUMENT

The Supreme Court did not set out the criteria for physician-assisted death

The Document’s stated purpose is to articulate “the criteria for physician-assisted death as set out by the SCC”. The SCC, however, did not set out those criteria. Rather, the Court simply identified the nature of the inconsistency between the criminal law provisions and the *Charter of Rights and Freedoms*.

The Supreme Court did not create an exemption through which individuals can access assisted suicide or euthanasia, in contrast to both the trial judgement and the Court of Appeal’s recommendation. The trial judge gave the plaintiff, Ms. Taylor, an exemption with a significant list of conditions, including the requirement that her attending physician must attest that she “is terminally ill and near death, and there is no hope of her recovering” before aiding her suicide.⁴ The Court of Appeal, which found itself bound by *Rodriguez*⁵ and therefore upheld the law, recommended that the SCC not strike down the law, but rather create an exemption allowing qualifying individuals to obtain assistance in suicide or euthanasia.⁶

The Supreme Court took neither the trial judge’s approach nor the Court of Appeal’s recommended approach. In short, it did not set out the criteria for physician-assisted death. Rather, the Court specifically declined to craft a remedy or set out the necessary rules and safeguards, concluding, “Parliament must be given the opportunity to craft an appropriate remedy.”⁷

Without clear standards enacted by Parliament, the CPSO risks misinterpreting the *Carter* ruling, which partially invalidated certain *criminal* law provisions. With respect, the Document overlooks 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. Even after the *Carter* ruling takes effect, the CPSO must not, in the absence of legislation, attempt to instruct its members on how to interpret and apply the SCC’s ruling in *Carter*.

The CPSO Document later states, “Physicians must use their knowledge, skill and judgment to assess an individual’s suitability for physician-assisted death, against the above criteria.” The “criteria” referred to are taken from the Supreme Court’s “declaration of invalidity” in *Carter*. The problem here is that the “suitability” for assisted suicide or euthanasia, even if considered a medical question in certain respects, is also a legal question. More specifically, the legal question is: in what circumstances and by what process may one person

³ RSQ c S-32.0001.

⁴ *Carter v. Canada (Attorney General)*, 2012 BCSC 886, at para 1414 [*Carter* trial decision].

⁵ *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519.

⁶ *Carter v. Canada (Attorney General)*, 2013 BCCA 435, at para 334 [*Carter* Court of Appeal decision].

⁷ *Carter*, *supra* note 1, at para 125.

participate in the suicide or euthanasia of another person without attracting criminal liability? This is a question to which the SCC did not intend to provide a precise answer and which the CPSO lacks jurisdiction to answer.

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

Under Canada’s Constitution, the 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 CPSO. 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”,⁸ the Court left up to Parliament the establishment of the necessary conditions, restrictions, and legal standards dividing criminal from non-criminal assisted suicide or euthanasia.⁹

In *Carter*, the SCC reaffirmed that Parliament has authority to legislate with respect to assisted suicide under the *Constitution Act, 1867*.¹⁰ 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 governed by medical regulatory authorities. Rather, the ruling “simply renders the criminal prohibition invalid”¹¹ as the prohibition applies to the factual circumstances of the *Carter* case.¹²

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”¹³ that “imposes strict limits that are scrupulously monitored and enforced”¹⁴ is capable of protecting vulnerable persons from abuse and error. The *Carter* decision clearly anticipates a *legislative* response to create such a regime. The SCC states that a complex regime is necessary to give effect to its limited exception to the assisted suicide prohibition, but it does not outline such a regime itself, because “[c]omplex regulatory regimes are better created by Parliament than by the courts.”¹⁵ With respect, the necessary regime for implementing the *Carter* decision, properly understood, is beyond the jurisdiction and capacity of the CPSO or any other medical regulatory authority.

The CPSO’s authority is derived solely from provincial statutes and regulations. Provincial law does not give the CPSO authority to determine when and under what circumstances assisted suicide falls within a limited judicial invalidation of certain *Criminal Code* provisions. 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 CPSO.

⁸ *Ibid*, at para 127.

⁹ *Ibid*, at para 125.

¹⁰ *Ibid*, at paras 49-53.

¹¹ *Ibid*, at para 132.

¹² 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.”

¹³ *Ibid*, at para 3.

¹⁴ *Ibid*, at para 27.

¹⁵ *Ibid*, at para 125.

***Criminal Code* provisions beyond those examined in *Carter* require may 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).¹⁶

Health care providers in Ontario could remain at risk of criminal charges under the above provisions. Assisted suicide or euthanasia should not be permitted to occur in Ontario or any other province until these matters are adequately addressed by Parliament.¹⁷ The SCC in *Carter* did not intend to deal comprehensively with the criminal law implications of its ruling, deliberately leaving that to Parliament.

Counselling a person to commit suicide remains a crime under section 241(a) of the *Criminal Code*. Depending on how a physician presents the patient’s prognosis and options, a patient might perceive the physician to be recommending assisted suicide. *Carter* does not turn assisted suicide or euthanasia into a regular health service that should be mentioned as part of a list of “options for care”. Rather, the ruling “simply renders the criminal prohibition invalid.”¹⁸ The CPSO and its members would do well to await clarification from Parliament as to what will be considered counselling a person to commit suicide.

***Carter* legalizes “physician-assisted dying” in narrow circumstances not including psychological suffering or mental illness**

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”.¹⁹ 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.”²⁰

¹⁶ 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>>.

¹⁷ We recognize the situation in Quebec, in which the Quebec Court of Appeal, in *D’Amico c. Procureure générale du Québec*, 2015 QCCA 2138 [*D’Amico*], found that Quebec’s legislation governing assisted dying may take effect. Whether or not Quebec’s legislation complies with the criminal law as interpreted in light of *Carter* was a live question before the SCC at the January 11, 2016 hearing of the Attorney General of Canada’s motion requesting that the SCC extend the suspension of its declaration on *Carter*. In any case, even *D’Amico* signals that at a minimum, provincial legislation is needed to address the risks inherent in permitting assisted suicide or euthanasia as identified by all levels of court in *Carter*. See footnote 30, *infra*. Also, the reason the Canadian government is requesting an extension of the criminal prohibition on assisted suicide is because legislation has not yet been passed but is considered necessary before any “assistance in dying” is provided.

¹⁸ *Carter*, *supra* note 1, at para 132.

¹⁹ *Ibid*, at para 56.

²⁰ *Ibid*, at para 127.

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 of Ms. Taylor’s case. 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.²¹

The right to life of Ms. Taylor and persons in her position 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.²² 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.²³ 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”.²⁴ 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.²⁵ These are the only “circumstances” in which the declaration of invalidity in *Carter* 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.”²⁶

The Document states, under heading IV-A-4 (“Enduring suffering that is intolerable”) that “physical and/or psychological suffering” qualifies. With respect, while recognizing that physical and psychological suffering often go together, *Carter* does not invalidate the criminal prohibitions on assisted suicide and euthanasia (“consensual homicide”) as they apply to situations not involving severe physical suffering. The phrase quoted above appears to suggest that a physician may provide assistance in suicide or euthanasia for a person suffering psychologically, whether their psychological suffering is connected to a “progressive illness” or not. However, it is not at all clear that “assistance in dying” provided as a response to depression, for example, would be legal even once *Carter* comes into effect. In fact, the SCC in *Carter* explicitly stated that “euthanasia for...persons with psychiatric disorders”²⁷ was outside of the scope of its reasons and the trial judge specifically precluded

²¹ The Document errs where it says, under heading IV-A-3 (“Grievous and irremediable medical condition”), that the SCC determined that the law violated the constitutional rights of “the two lead plaintiffs”, referring to Gloria Taylor and Kathleen Carter. Kathleen Carter, who had spinal stenosis, was not a plaintiff in *Carter*. Rather, her daughter Lee Carter was a plaintiff, and her claim was based on the fact that she risked prosecution in Canada by participating in arranging her mother’s death in Switzerland. As the Supreme Court stated at para 69, *ibid*:

We note, as the trial judge did, that Lee Carter and Hollis Johnson’s interest in liberty may be engaged by the threat of criminal sanction for their role in Kay Carter’s death in Switzerland. However, this potential deprivation was not the focus of the arguments raised at trial, and neither Ms. Carter nor Mr. Johnson sought a personal remedy before this Court. Accordingly, we have confined ourselves to the rights of those who seek assistance in dying, rather than of those who might provide such assistance.

See also paras 30, 32, 42, 56, 65, 66, and 127.

²² *Ibid*, at paras 30, 57-58.

²³ *Ibid*, at paras 64-69.

²⁴ *Ibid*, at para 67.

²⁵ *Ibid*, at para 66.

²⁶ *Ibid*, at para 111.

²⁷ *Ibid*, at para 111.

physician assisted suicide for those who are clinically depressed.²⁸ Depression or mental illness, among other ailments, would fall under “other situations where physician-assisted dying may be sought”—situations to which the *Carter* ruling does not apply.²⁹

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 the CPSO should not be issuing policies on the subject before then.

Adequate reporting and independent oversight is essential

The SCC stated in *Carter*:

[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.³⁰ Such error and abuse can only be substantially minimized through the scrupulous monitoring and enforcement of a detailed system of safeguards.

The Document is commendable for requiring clear documentation of all steps leading to the provision of assisted suicide or euthanasia, but it is doubtful that the CPSO’s *Medical Records* policy satisfies the “scrupulous monitoring and enforcement” considered necessary by the Supreme Court in order to prevent error and abuse. Assisted death is unlike other medical practices because in all cases the victim of error or abuse will be deceased. This explains in part why the criminal law does not allow consent as a defence to homicide. The presence or absence of consent is commonly disputed in assault cases (including in a medical context), for example, with the alleged victim ordinarily serving as a primary witness. Once physician-assisted dying has been carried out, however, the victim of course cannot be a witness. Whether the deceased person truly gave informed consent free from coercion or undue influence is difficult to determine. Extra care is needed here. The amount and type of documentation required may yet be set out by Parliament or the Ontario legislature. We recommend that the CPSO encourage its physicians not to participate until clear guidance is received through legislation.

²⁸ *Carter* trial decision, *supra* note 4, at para 1388.

²⁹ *Carter*, *supra* note 1, at para 127.

³⁰ See for example the abuses and problems listed in *Carter* trial decision, *supra* note 4, at paras 472, 475, 484, 502, 554, 556, 561-562, 568, 649, 656, 669, 670, 766-767, 815, 847, and 853.

The Document does not respect physicians' constitutional freedom of conscience

Part IV-C of the Document (“Conscientious Objection”) violates physicians’ freedom of conscience by requiring participation in the form of effective referrals and violates freedom of conscience and expression by requiring physicians to inform patients of “all options for care” (which from the context presumably includes assisted dying), to state that their objection to assisted suicide or euthanasia is “personal and not clinical”, and to communicate that objection without expressing any “personal moral judgement”.

The requirement to provide a referral clearly and unjustifiably interferes with freedom of conscience because it forces physicians to participate in an act to which they are conscientiously opposed. The connection between referral and the act itself was reflected in the CPSO president’s statement in response to the controversy surrounding the introduction of Policy 5-08 in 2008³¹ that the CPSO was “not asking doctors to be complicit by making a referral.”³² Since then, of course, the CPSO has asked physicians to be complicit by modifying its policy to require referrals. Since requiring a referral interferes with freedom of conscience and religion, it must be demonstrably justified.³³ Requiring referrals is difficult to justify, especially when it comes to referring for assisted suicide or euthanasia, which have never been a component of health care services in Ontario and which are not medically necessary. Even if the procedure for which a referral is required is medically necessary and urgent, the CPSO must demonstrate that it cannot find a way to reasonably accommodate physicians’ conscientious and religious objections. When it comes to assisted suicide and euthanasia, it has not done so.

Carter does not turn assisted suicide or euthanasia into a regular health service that must be mentioned as part of a list of “options for care”³⁴, but “simply renders the criminal prohibition invalid.”³⁵ Nothing in *Carter* suggests physicians cannot express disapproval of assisted suicide or euthanasia. And, as mentioned above, counselling suicide is a crime. A physician may recommend chemotherapy treatment for cancer, but he or she may not recommend assisted suicide. Yet the Document seems concerned only with physicians communicating anything negative about assisted suicide or euthanasia to the patient.

The Document states that if a physician objects, he or she must inform the patient that the objection is due to “personal and not clinical reasons” and “[i]n the course of communicating an objection, physicians must not express personal moral judgements about the beliefs, lifestyle, identity or characteristics of the patient.” However, as recognized by the Canadian Medical Association in a 2007 statement, “[e]uthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. ... For the medical profession ... to participate in these practices, a fundamental reconsideration of traditional medical ethics would be required.”³⁶ A poll taken of CMA members in August 2015 indicated that 63% of physicians would not provide assistance in dying if it were requested by the patient (an additional

³¹ In 2008, the CPSO introduced a new policy statement, “Physicians and the Ontario Human Rights Code,” Policy 5-08, which warned physicians that a decision to restrict their services that is based on religious or moral beliefs may be discriminatory and contrary to the *Ontario Human Rights Code*. This Policy failed to account for the constitutional freedom of conscience and religion and the fact that the *Human Rights Code* prohibits discrimination based on creed.

³² Stuart Laidlaw, “Does faith have a place in medicine?” *The Toronto Star*, September 18, 2008, online: <http://www.thestar.com/life/health_wellness/2008/09/18/does_faith_have_a_place_in_medicine.html>.

³³ *Canadian Charter of Rights and Freedoms*, at section 1.

³⁴ Document, Part IV-C, under the heading “Conscientious Objection”, at bullet point 3.

³⁵ *Carter*, *supra* note 1, at para 132.

³⁶ Canadian Medical Association. Canadian Medical Association policy. *Euthanasia and assisted suicide (update 2007)*, Web:<<http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf>>.

8% were undecided).³⁷ It may be the position of the CPSO to force its members to comply with a fundamentally new ethic, but nothing in *Carter* requires it to so. Moreover, there is no strict separation between what a physician considers “clinical” or medically necessary and his or her position ethical position on certain “treatments”. Many physicians believe “assisted dying” is unethical, and many do not consider it to be health care. The CPSO cannot require them to be silent about their ethical objections to assisted suicide or euthanasia in their medical practice.

Would a physician who communicates to the patient his or view that assisted suicide is unethical and is not health care violate the Document? What about a physician who suggests to her patient that there is hope for her situation and encourages her to consider alternative options rather than suicide (a relevant scenario considering the recommendations of the Provincial Advisory Group to make assisted suicide available to children, the non-terminally ill, and those with psychological illness)?³⁸ Would such conversations amount to expressing “personal moral judgment”? The answer to these questions is not clear from the Document. The Document’s vague warning about expressing “personal moral judgment” on a matter that is universally recognized to raise fundamental questions of medical ethics creates a chilling effect and limits both freedom of conscience and freedom of expression.

The Document could expose CPSO and its members to liability

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

The CPSO 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 CPSO 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 need for careful capacity assessment and documentation. However, in light of the legal issues and areas of potential liability outlined above, CLF submits that the Document is inappropriate at this time, unworkable, and most importantly, purports to resolve

³⁷ “Many doctors won’t provide assisted dying”, *Canadian Medical Association Journal*, August 31, 2015, Web: <<http://www.cmaj.ca/content/early/2015/08/31/cmaj.109-5136.full.pdf>>.

³⁸ Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, “Final Report”, November 30, 2015, at pp 15, 34.

legal issues that are outside of the CPSO's authority. We urge the CPSO to wait until legislation governing this difficult matter has been enacted.

Until then, the CPSO might serve those patients who are suffering most severely by continuing to improve Ontario physicians' training in pain management and end-of-life care.

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

Sincerely,

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

John Sikkema, J.D. Associate Legal Counsel

CHRISTIAN LEGAL FELLOWSHIP