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January 22, 2016

SUBMISSION OF CHRISTIAN LEGAL FELLOWSHIP
RE: ONTARIO CONSULTATION ON "PHYSICIAN-ASSISTED DYING" AND END-OF-LIFE DECISIONS

To: The Honourable Madeleine Meilleur, Attorney General of Ontario
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
CC: The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada

Sent via email to:
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Dear Attorney General and Minister of Health of Ontario,

First of all, we wish to thank the government for conducting consultations on the important and difficult issue of physician-assisted suicide and euthanasia, referred to together as "physician-assisted dying" ("PAD") by the provincial government in its consultation.

We write this letter on behalf of Christian Legal Fellowship (CLF), Canada's largest association of Christian lawyers, in order to assist the government in working through the legal issues—particularly the division of powers and *Charter* issues—involved in forming a provincial legislative response to *Carter*[1].

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] *Carter v Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

CLF has developed considerable expertise in this matter. CLF intervened in all levels of court in *Carter* and in the recent motion for a further suspension of the declaration of invalidity in *Carter*. CLF also intervened in both levels of court in *D'Amico c. Québec (Procureure générale)*[2], a case that remains ongoing. 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, Ontario, and New Brunswick on this issue.[3]

THE LEGAL CONTEXT

In this part, we explain the implications of the concurrent federal and provincial jurisdiction over health and the implications of the *Carter* judgement with respect to federal and provincial government roles in regulating assisted suicide and euthanasia.

Province's constitutional jurisdiction

Section 92(7) of the *Constitution Act, 1867* authorizes the provinces to make laws in relation to "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals." Section 92(13) confers on the provinces jurisdiction over "property and civil rights in the province", which has been interpreted to cover contract, tort, property, and insurance, including health insurance. It also covers regulation of the professions, including the health care professions.[4] Provincial power over health stems primarily from these provisions.

Parliament's constitutional jurisdiction[5]

Federal power over health is rooted in section 91(27) of the *Constitution Act, 1867*, which gives the federal government exclusive jurisdiction over criminal law. Criminal law must possess three elements: (1) a prohibition, (2) backed by a penalty, (3) which advances a criminal law purpose such as public peace, safety, order, security, morality, health, environmental protection, or "some similar purpose."[6]

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.[7] In each of these areas, federal laws have passed constitutional challenges on division of powers grounds, each being a legitimate exercise of Parliament's criminal law power.[8] In *Canada v PHS Community Services Society*[9], the SCC, citing its *Morgentaler 1975*[10], *1988*[11], and *1993*[12] decisions, reiterated that Parliament "has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as 'socially undesirable' behavior".[13]

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[2] 2015 QCCS 5556 [*D'Amico* trial] and 2015 QCCA 2138 [*D'Amico* appeal]. The Quebec Court of Appeal ruling on paramountcy question, which overturned the motion ruling from the Court below, may yet be appealed. The main application has not yet been heard by the lower court (Superior Court) in Quebec.

[3] CLF's submissions in each of these matters are available online at www.christianlegalfellowship.org.

[4] Peter Hogg, Constitutional Law of Canada, 5th Edition Supplemented (December 1, 2014), at 32-2 [Hogg].

[5] For a more comprehensive treatment of the extent of Parliament's jurisdiction to regulate assisted suicide and euthanasia after *Carter*, see the Association for Reformed Political Action, *Stemming the Tide: How Parliament must mitigate the harm of assisted suicide*, 2015, Web, <https://goo.gl/OQGFIC>.

[6] *AHRA Reference*, 2010 SCC 61, [2010] 3 SCR 457, at para 43; *Reference re Validity of Section 5 (a) Dairy Industry Act*, [1949] SCR 1, at 49.

[7] Hogg, *supra* note 4, at 32-4.

[8] See *ibid*, at 32-3 to 32-4.

[9] 2011 SCC 44 [*PHS*]. It was argued in *PHS* that the federal law prohibiting drug possession should not apply to a safe injection clinic established by the province of British Columbia.

[10] *Morgentaler v The Queen* (1975), [1976] 3 SCR 616, at 627.

The *Charter*, *Carter*, and the division of powers

In *Carter v Canada*, the SCC declared that sections 14 and 241(b) of the Criminal Code are void to the extent that they prohibit physician-assisted death for a "competent adult person who clearly consents to the termination of life and who has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."[14] This declaration was based on the finding that these provisions violated the *Charter* rights (section 7) of Ms. Taylor, who had Amyotrophic Lateral Sclerosis, and of "persons in her position".[15]

However, the Court also found that sections 14 and 241(b) of the *Criminal Code* were within Parliament's criminal law power to enact and did not interfere with the "core" of any provincial head of power. Health care professionals, hospitals, and clinics are all bound by applicable federal laws. The criminal law restricts what these persons and institutions may do as health care service providers. The Court's declaration of the (partial) invalidity of the two criminal law provisions in *Carter* does not alter that fact. The *Charter* does not alter the division of powers. As McLachlin C.J. wrote for a unanimous Court in *PHS*:

> There is no conflict between saying a federal law is validly adopted under s. 91 [of the *Constitution Act, 1867*] and asserting that the same law, in purpose or effect, deprives individuals of rights guaranteed by the *Charter*. […] Indeed, if the *CDSA* were *ultra vires* the federal government, there would be no law to which the *Charter* could apply. Laws must conform to the constitutional division of powers and the *Charter*.[16]

In *Carter v Canada* the SCC found that the prohibition on assisted suicide was a valid exercise of Parliament's criminal law power. By effectively declaring that section 7 of the *Charter* requires exemptions to be made to the general prohibition, the Court was not turning assisted suicide—including physician-assisted suicide—into a non-criminal matter, at least not exclusively, just as in *PHS*[17] the SCC did not turn narcotics possession, even in a clinical setting, into a non-criminal matter. Rather, the SCC found in both cases that *Charter* rights will in certain limited circumstances, in individual cases, require exemptions to general criminal prohibitions,[18] and as the Court stated in another case, "the criminal law may validly contain exemptions for certain conduct without losing its status as criminal law."[19]

What remains to be seen is whether the federal government will enact a comprehensive legislative regime under its criminal law power. Such a regime could validly delineate the circumstances in which an exception to the general prohibition may be made and could also set out the required procedure for making use of the exception. We have seen examples of such a scheme with abortion,[20] firearms,[21] and assisted

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[11] *R v Morgentaler*, [1988] 1 SCR 30.
[12] *R v Morgentaler,* [1993] 3 SCR 463.
[13] *PHS*, *supra* note 9, at para 68.
[14] *Carter*, *supra* note 1, at para 127.
[15] The SCC repeatedly refers to Ms. Taylor and people like her in the course of its *Charter* analysis. At the close of its Charter analysis, the Court reiterates the limited scope of its ruling with two statements: "To the extent that the 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, 1982." And: "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] *PHS*, *supra* note 9, at para 82.
[17] *Ibid*.
[18] *Carter*, *supra* note 1, at para 127.
[19] *[1995] 3 SCR 199 [RJR-MacDonald]*, at para 53.
[20] Section 287 of the *Criminal Code*, RSC, 1985, c C-46 (formerly section 251, at the time of *Morgentaler 1988*).
[21] *Reference Re Firearms Act*, 2000 SCC 31, [2000] 1 SCR 783. The SCC upheld the entire federal *Firearms Act* (SC 1995, c 39) as it then was, as a valid exercise of Parliament's criminal law power. The Act required the registration of firearms and the licensing of owners

human reproduction.[22] A strict and comprehensive federal regime is desirable in this case because assisted suicide and euthanasia are matters of fundamental societal importance, raise serious ethical questions, and involve a serious risk of abuse. The criminal law has traditionally been the vehicle for addressing such matters,[23] and our constitution assigns criminal law power to Parliament.

Why are physicians involved?

Many physicians do not consider assisted suicide or euthanasia to be health care at all. A recent poll of Canadian physicians revealed that 63% would not consider providing medical aid in dying, with a further 8% undecided.[24] In 2007, the Canadian Medical Association stated in its policy that "[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."[25]

Yet *Carter* dealt with physician-assisted suicide and the Court declared that the criminal provisions in issue were "void insofar as" they applied to "physician-assisted dying" in the factual circumstances of *Carter*. Why? The SCC did not create a limited exception for physician-assisted suicide because assisted suicide or euthanasia is a "health care option" that provinces should provide and regulate in a similar manner to existing health care services. Rather, a complete prohibition was found to be unnecessary for protecting the vulnerable *only* where physicians are involved, because the Court considered physicians uniquely capable of deciphering who is vulnerable and thus ensure their protection. Had the Court lacked confidence that there are persons who can reliably assess the vulnerability and competence of severely sick people, it would have had to uphold the criminal law prohibition under section 1 of the *Charter*.

This makes sense of the Court's statement that its declaration "simply renders the criminal prohibition invalid" and that "nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying". Physicians are professionally obligated to act in patients' best interests, but *Carter* does not say assisted suicide or euthanasia is in any patient's best interests and it appears many or most physicians would agree. The Advisory Group's Report is plainly wrong in saying (at page 3) that, "[e]ffective February 6, 2016, all provinces and territories must ensure access to physician-assisted dying." The (partial) invalidation of a criminal prohibition does not translate into a positive mandate for any government to "ensure access" to assisted suicide or euthanasia.

The scope of the invalidation of the criminal law provisions

Any provincial legislation must not purport to authorize assisted suicide or euthanasia in as broad a range of circumstances as contemplated by the Report of the Provincial/Territorial Expert Advisory Group on

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of firearms. However, as the SCC pointed out (in para 37), "The fact that the Act is complex does not necessarily detract from its criminal nature."

[22] Portions of the *Assisted Human Reproduction Act* (AHRA) were invalidated by the Supreme Court in the *AHRA Reference*, 2010 SCC 61, [2010] 3 SCR 457. Notably, however, the provisions upheld by a majority of the Court included general prohibitions on certain activities with conditional exceptions requiring compliance with certain procedures to access them. Section 8 of the *AHRA*, for example, prohibited the use of human reproductive material for certain purposes, unless the consent of the donor has been given in writing and in accordance with the regulations.

[23] McLachlin C.J., *ibid*, at para 1.

[24] "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>.

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

Physician-Assisted Dying, which recommends that assisted suicide and euthanasia be publicly funded and available for the non-terminally ill, the mentally ill, and for minors.

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".[26] 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."[27]

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.[28]

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.[29] 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.[30] 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".[31] 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.[32] 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."[33]

THE PROVINCIAL GOVERNMENT'S ROLE

The provinces may have a role to play in determining *how* PAD can be made available, such as what particular procedures to use and how to assess and record patient capacity and consent, in those circumstances where PAD is permitted by criminal law. This may depend in part on how comprehensive any legislation Parliament enacts will be. Parliament may also legislate with respect to the procedures, safeguards, and oversight of physician-assisted suicide and euthanasia, provided it does so pursuant to a criminal law purpose, such as ensuring the vulnerable are adequately protected, promoting public safety,

[26] *Ibid*, at para 56.
[27] *Ibid*, at para 127.
[28] See *Carter*, *supra* note 1, at paras 30, 32, 42, 56, 65, 66, 69, and 127.
[29] *Ibid*, at paras 30, 57-58.
[30] *Ibid*, at paras 64-69.
[31] *Ibid*, at para 67.
[32] *Ibid*, at para 66.
[33] *Ibid*, at para 111.

and determining based on fundamental ethical and societal considerations who is eligible or not eligible for assisted suicide or euthanasia. The provincial government should encourage Parliament to do so.

However, should the manner of access and patient assessment not be set out in federal law, the province will need to legislate. Given the significantly more complex issues inherently involved, existing medical procedures for assessing competence and obtaining and recording consent to treatment are not directly transferable to PAD. If Parliament does not, the government of Ontario must establish a system of procedural safeguards and reliable, independent oversight. The province should ensure that the details of every request for PAD is carefully recorded, which record should include the reasons given by the patient for requesting PAD and the reasons a physician gives for approving or not approving the request. Only such reporting will allow overseers to ensure the law is being complied with.

Accurate reporting and adequate oversight

While the SCC in *Carter* agreed with the trial judge that physicians possess the knowledge and skill to assess competence and to detect coercion, undue influence, and ambivalence as part of the assessment process,[34] it was clearly persuaded that assisted suicide and euthanasia require far more than a routine capacity assessment. As the Court stated:

> [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:
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> > … 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 in *Carter* found that everywhere assisted suicide or euthanasia has been legalized, there has been some error and abuse.[35] Such error and abuse can only be "substantially minimized" through the scrupulous monitoring and enforcement of a detailed system of safeguards.

It is doubtful that the College of Physicians and Surgeons of Ontario's existing *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. Extraordinary care is needed here. The amount and type of documentation and the procedure for completing PAD should be set out in provincial law, if not adequately addressed in federal law.

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[34] *Supra* note 1, at para 27.

[35] See for example the abuses and problems listed in *Carter* trial decision, 2012 BCSC 886, at paras 472, 475, 484, 502, 554, 556, 561-562, 568, 649, 656, 669, 670, 766-767, 815, 847, and 853.

Free and informed consent

Given the physician's position of trust and authority and the inherent if subtle influence of his or her comments regarding treatment options, the physician should never be the first to mention assisted suicide or euthanasia as an option. Only if the patient asks about it should the physician give information about its availability. Along with that information, the physician must list "alternative courses of action" to PAD in accordance with section 11(3) of the *Health Care Consent Act*,[36] including palliative care, palliative sedation, pain management, and any other reasonable treatments available.

Conversely, if a patient requests palliative care or other treatment, physicians should not list PAD as an option. As explained above, *Carter* does not turn assisted suicide or euthanasia (which is technically homicide) into a health care service. Rather, it "simply renders the criminal prohibition invalid."[37] There is no law against suicide,[38] but physicians are not expected to include suicide among the options they suggest to a patient, even though suicide, assisted or not, can be a means to end "grievous and irremediable suffering." Neither should a physician mention assisted suicide or euthanasia as an alternative.

Counselling a person to commit suicide is a crime under section 241(a) of the *Criminal Code*. This section was not declared invalid in *Carter*. Counselling a person to commit suicide by filling out and taking a lethal prescription would still be contrary to section 241(a), just as counselling a person to commit suicide by any other means remains a crime. Conversely, advising a patient to undergo chemotherapy, pain management, or other health care treatment is no crime.

Protecting freedom of conscience

As noted above, euthanasia and assisted suicide are matters of controversy within the medical profession. "For the medical profession … to participate in these practices, a fundamental reconsideration of traditional medical ethics would be required," the Canadian Medical Association said just a few years ago.[39] The province should not force a revolution in medical ethics onto unwilling physicians. Nothing in *Carter* requires this. Rather, the provincial government must ensure that physicians' constitutional freedom of conscience is not violated. A good way to do this—and to simultaneously ensure that physicians are properly trained before becoming involved PAD—is to make the system "opt in" rather than "opt out". That is, physicians who wish to provide PAD should be required to complete a thorough training program. No physician who has not completed such a program may participate in PAD, and no physician who does not wish to participate should be required to complete such a program.

Provincial legislation should preclude the College of Physicians and Surgeons of Ontario (CPSO) from requiring referrals for PAD. 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 CPSO asks physicians to be complicit in its "Interim Guidance on Physician-Assisted Death" by requiring referrals.

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[36] SO 1996, c 2, Sch A.
[37] *Carter*, para 132.
[38] The law against *attempted* suicide was removed from the *Criminal Code* in 1972, as noted by the SCC in *Rodriguez v. British* Columbia (Attorney General), [1993] 3 SCR 519.
[39] Canadian Medical Association. Canadian Medical Association policy. *Euthanasia and assisted suicide (update 2007),* Web:<http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf>.

In its submission to the CPSO, the Canadian Medical Association (CMA) focused primarily on the issue of the CPSO's requirement to provide a referral.[40] The CMA articulated the issue well:

> There are different notions of conscience that fall along a spectrum of morally acceptable involvement in any given act as, for example, opposition, procedural non-participation, non-interference, and participation. For the majority […] referral is entirely morally acceptable; it is not a violation of their conscience. For others, referral is categorically morally unacceptable; it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. […]
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> It is the CMA's strongly held position that there is no legitimate justification to respect one notion of conscience (i.e. the right not to participate in assisted dying), while wholly discounting another because one may not agree with it. [41]

The moral complicity of indirect participation in an act is well recognized. The World Medical Association, for example, has adopted a Resolution "that it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process, including its planning and the instruction and/or training of persons to perform executions."[42]

Requiring a physician who objects to PAD for reasons of conscience or religious belief to provide a referral interferes with his or her freedom of conscience and religion. The *Charter* applies to any government law or policy that would so interfere. Any such interference must be *demonstrably justified* in accordance with section 1 of the *Charter*. Requiring referrals is extremely 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.

A note regarding ongoing litigation in Quebec and implications for Ontario

On December 1, 2015, the Superior Court of Quebec declared that portions of Quebec's *An Act Respecting End-of-Life Care* purporting to authorize "medical aid in dying" were inoperative under the doctrine of paramountcy because they flagrantly contradict *Criminal Code* prohibitions that remain in force. The Attorney General of Quebec appealed. The Court of Appeal overturned the Superior Court's finding that Quebec's law is inoperative, reasoning that paramountcy only applies to a conflict between a valid federal law and a valid provincial law, and that the federal law, though it would remain in force until at least February 6, 2016 (and now, with the additional 4-month suspension,[43] until June 6), is not really "valid", since it was declared invalid in Carter.

In our view, the Court of Appeal's decision confuses the issue of "validity" as it applies in the doctrine of paramountcy. The reason paramountcy is said to apply only where two valid laws are in place is because it takes two *operative* laws to have a conflict of laws. Often, in federalism disputes, it will be argued that one or both of the federal and provincial laws in question are *ultra vires* (beyond the authority of) the enacting body. If one of the laws is *ultra vires*, it is effectively no longer a law. There is then only one law, meaning there can be no conflict of laws.

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[40] Canadian Medical Association, "CMA's Submission to the College of Physicians and Surgeons of Ontario – Consultation on CPSO Interim Guidance on Physician-Assisted Death", January 13, 2016, Web, <http://policyconsult.cpso.on.ca/wp-content/uploads/2016/01/CMA-Submission-to-CPSO.pdf>.
[41] *Ibid*, at 1-2.
[42] World Medical Association, "WMA Resolution on Physician Participation in Capital Punishment", adopted in 1981 and amended in 2000 and 2008, Web, <http://www.wma.net/en/30publications/10policies/c1/>.
[43] See *Carter v Canada (Attorney General)*, 2016 SCC 4 [*Carter* (2016)].

The Quebec Court of Appeal takes the term "validity" as it appears in paramountcy jurisprudence and applies it to *Criminal Code* provisions that have been declared partially invalid under the *Charter of Rights and Freedoms*. However, the declaration of invalidity in *Carter* has been suspended, so the criminal law provisions currently remain in force. The conflict with Quebec's law is therefore real and obvious. The reason paramountcy does not apply in cases where one law is invalid is because it isn't needed—the finding of invalidity or *ultra vires* eliminates any conflict. A declaration of *ultra vires*, unlike a declaration that a law violates the *Charter*, is never suspended but takes effect immediately, meaning the apparent conflict disappears immediately. That is plainly not the case here.

This ruling on the paramountcy issue may yet be appealed. Even if it is not, the litigation in *D'Amico* will remain ongoing, since the ruling on paramountcy was made on a preliminary motion and is not dispositive of the case. The Supreme Court in *Carter* (2016) granted Quebec's requested exemption, but added, "In doing so, we should not be taken as expressing any view as to the validity of the [*Act Respecting End-of-Life Care*]."[44]

At the *Carter* (2016) hearing, Justice Karakatsanis asked whether the Attorney General of Canada's support for Quebec's request for an exemption implies that Quebec's law complies with the *Criminal Code* as read in light of *Carter*. The Attorney General of Canada did not take a position on the question and the Court did not answer the question in its judgement.

However, it is clear that no province has authority to broaden the scope of *Carter* through legislation. The provision of PAD by physicians in Ontario remains and will remain subject to criminal law. This is fundamentally a question of the dividing line between criminal and non-criminal participation by anyone, including health care professionals, in another person's death, which is a criminal law question.[45] Questions such as whether Canadian society should permit assisted suicide or euthanasia for the mentally ill, minors, non-terminally ill persons, persons with non-debilitating, non-degenerative, or minor illnesses, or anyone at all, are criminal law questions. The provincial government should therefore take a cautious approach, addressing only those aspects of PAD that fall clearly within its jurisdiction if these have not been adequately addressed as part of a comprehensive regime enacted by Parliament.

Sincerely,

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Executive Director

John Sikkema, J.D.
Associate Legal Counsel
CHRISTIAN LEGAL FELLOWSHIP

[44] *Ibid*, at para 4.
[45] The basic criteria governing who may be euthanized or whose suicide may be assisted involve serious questions of public morality and core societal values – see *Carter*, *supra* note 1, at paras 76, 98. The Court also finds (at paras 49-53) the impugned provisions to be within Parliament's criminal law jurisdiction.