Submission to Special Joint Committee on Physician-Assisted Dying

-*Carter* Requires Conscience Protections and Safeguards for the Vulnerable-

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This submission is written jointly by a medical doctor, specializing in adult pulmonary medicine, and a lawyer who practices in the area of criminal and constitutional law. We submit that Parliament is required by *Carter* to act to protect the conscience rights of health care workers and to safeguard the vulnerable. In this submission, we make specific legislative recommendations.

SUMMARY OF TOPICS AND RECOMMENDATIONS

I. **PARLIAMENT MUST ENACT CONSCIENCE PROTECTIONS**:
Carter requires Parliament to specifically legislate protections for individuals and groups in the healthcare field who object on matters of conscience.

Recommendation 1: It is proposed that Parliament provide explicitly that health care workers and/or institutions cannot be subject to obligation or sanction, including professional sanction, as a result of their failure to participate in physician assisted suicide or euthanasia.

II. **PARLIAMENT MUST ENACT SAFEGUARDS TO PROTECT THE VULNERABLE**:
Carter requires Parliament to ensure measures are taken to protect the vulnerable.

Recommendation 2: Parliament should define a "grievous and irremediable" medical condition as a clearly diagnosed terminal medical condition.

Recommendation 3: Parliament should legislate the following requirements in order for there to be recognized "clear consent":

- ***a. The patient must have access to the highest standard of medical care for their condition. This will ensure that people do not resort to assisted suicide or voluntary euthanasia due to unavailable medical treatment.***
- ***b. The patient must access to the highest standard of palliative care for the pain being suffered. This will ensure that people do not resort to assisted suicide due to unavailable pain management.***
- ***c. The patient must be free of undue influence or coercion. This may be best assessed by a multidisciplinary group including social workers, psychologists, community care workers, and other appropriate persons.***
- ***d. The patient must have access to counselling and spiritual care services.***

III. **A CRITIQUE OF CERTAIN RECOMMENDATIONS BY THE PROVINCIAL TERRITORIAL EXPERT ADVISORY GROUP**:

Certain recommendations made by this group, if enacted, would fail to protect conscience rights and vulnerable groups as required by *Carter*.

I. **PARLIAMENT MUST ENACT CONSCIENCE PROTECTIONS**:

The *Carter* decision in no way compels doctors or other healthcare workers to unwillingly cooperate in a suicide. *Carter* was based on two important factual conditions: a willing patient and a willing doctor. The applicants in *Carter* all had willing doctors. Had there been no willing doctor, the Supreme Court may have still held the applicants had a right to assisted suicide, but not necessarily by a physician. The finding of the Court in the specific case of Carter does not positively obligate physicians to add assisted suicide or euthanasia to their medical practices.

Many doctors and other healthcare workers object to assisted suicide and euthanasia on the grounds of moral conscience; others object as a matter of professional ethics, which is no less an objection of conscience. In paras. 130-132 of the *Carter* decision, the Supreme Court held "a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief." The Court then invited Parliament, along with provincial legislatures and physician's colleges, to implement a scheme which protects these rights.

Parliament should explicitly affirm that physicians and all other health care workers are not obligated in any way to participate in physician assisted suicide or voluntary euthanasia, either in the act of killing itself, or in the process which might lead to such a killing. Parliament should affirm that the failure to so participate does not infringe the rights of patients, and is not a reason for discipline or other sanction, either criminal or professional.

It is established law in Canada that doctors are not government actors, and therefore cannot violate the *Charter* rights of other individuals (see: *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483). Only government can violate the constitution, and under the constitution, doctors are private actors. The facts that doctors are regulated by a public body, that they are largely paid by public dollars, and that Canada has a system of socialized medicine, do not render doctors public actors whose conduct is measured against the *Charter*. Like lawyers, engineers, and other professionals, doctors are private actors. *Carter* does not and cannot place any obligation on individual physicians to assist in a suicide or euthanasia, especially where to do so would violate their fundamental freedoms of conscience and religion. This reasoning applies equally to protect other healthcare workers such as nurses and pharmacists, who are similarly private actors.

Some assume that the government has a positive obligation to facilitate assisted suicide or voluntary euthanasia for those who qualify per *Carter*. Firstly, it must be noted that this argument is made in the absence of any evidence establishing that access to assisted suicide and euthanasia will be a problem. However, even assuming this to be the case, a government obligation to facilitate a *Charter* right does not require individual non-government actors (i.e. healthcare workers) to be compelled to cooperate in an action to which they object as a matter of fundamental moral conscience. To the extent that government sets forward a scheme to facilitate access to assisted suicide and euthanasia, such a scheme cannot place obligations on or sanction individuals who object to assisted suicide or euthanasia as a matter of conscience. Individual physicians who object as a matter of conscience to assisted suicide or euthanasia

cannot be compelled to refer patients to another physician who will provide these, if this referral would also violate their consciences.

Parliament should also recognize the rights of patients who may wish to seek care in institutions where physician assisted suicide and euthanasia are not offered. This is an important matter of patient choice, especially for those patients who are not comfortable with physician assisted death, and for whom its existence undermines their trust in their physicians and damages the therapeutic relationship. Some patients have concerns that they will be coerced into physician assisted death, and that there will conflicts of interest (including possibly financial conflicts) regarding their care. The existence of institutions which do not provide physician assisted death will greatly assist such patients in maintaining confidence in the medical system.

> ***<u>Recommendation 1</u>: It is proposed that Parliament provide explicitly that health care workers and/or institutions cannot be subject to obligation or sanction, including professional sanction, as a result of their failure to participate in physician assisted suicide or euthanasia.***

There is clear precedent for similar legislation. In sections 3 and 3.1 of the *Civil Marriage Act*, 2005, Parliament enacted specific protections, and affirmed that the *Charter* protection of freedom of conscience and religion guarantees that individuals and groups are not required to perform same-sex marriages. These provisions also prevent such individuals and groups from being subject to any “obligation or sanction” as a result of their belief in respect of marriage as a union of a man and woman to the exclusion of all others.

Legislative authority over both marriage and assisted suicide / voluntary euthanasia are divided between Parliament and the Provincial and Territorial Legislatures. (See: *Reference re Same-Sex Marriage*, 2004 SCC 79 at para. 17 and *Carter v. Canada (Attorney General)*, 2015 SCC 5 at para. 53). Thus, there is a clear parallel between the present issue of assisted suicide and same-sex marriage. Parliament enacted conscience protections when legislating same-sex marriage. It should do so when legislating assisted suicide.

II. PARLIAMENT MUST ENACT SAFEGUARDS TO PROTECT THE VULNERABLE

In *Carter*, the Supreme Court of Canada held that assisted suicide is available in some circumstances to competent adults with grievous and irremediable conditions who clearly consent to the termination of life. They also held that any system for assisted suicide must be "properly designed and administered" with "safeguards … capable of protecting vulnerable people from abuse and error" (para. 105). The Supreme Court specifically left it to the purview of Parliament to legislate on the requirements for lawful assisted suicide. More specifically, the Court left it to Parliament to define what constitutes a "grievous and irremediable" medical condition and what amounts to "consent" to the termination of life.

Many have discussed how to define the requirement that a person seeking assisted suicide or voluntary euthanasia must have a "grievous and irremediable" medical condition. It must be noted in nearly all other jurisdictions where assisted suicide is permitted, there is a requirement that the patient be terminal (see p. 57 of the External Report). Parliament should so legislate in Canada. This requirement of terminal illness will have the added benefit of protecting those who may express a desire for assisted suicide due to mental health issues, or people who are otherwise marginalized.

> ***Recommendation 2: Parliament should define a "grievous and irremediable" medical condition as a clearly diagnosed terminal medical condition.***

The requirement in *Carter* that the patient "clearly consent" to the termination of life, though frequently overlooked, is an important and essential pre-condition to the exercise of assisted suicide. The meaning of the term "clear consent" must be fleshed out by Parliament. Clear consent is not a foreign term to law; rather, judges, lawyers, doctors, and many other professional and legal actors regularly analyze and unpack the concept of clear consent in different contexts. In the context of assisted suicide or euthanasia, where the decision is final and irreversible, the requirement for clear consent must be narrowly defined and stringently applied.

In order for there to be "clear consent" to an irreversible decision, there must be a guarantee that the patient is not coerced into suicide by unrelieved physical or emotional suffering, family, social or financial pressure, mental health issues, and myriad other personal or external factors.

> ***Recommendation 3: Parliament should legislate the following requirements in order for there to be clear consent:***
>
> ***a. The patient must have access to the highest standard of medical care for their condition. This will ensure that people do not resort to assisted suicide due to unavailable medical treatment.***
>
> ***b. The patient must have access to the highest standard of palliative care for the pain being suffered. This will ensure***

that people do not resort to assisted suicide due to unavailable pain management.

c. ***The patient must be free of undue influence or coercion. This may be best assessed by a multidisciplinary group including social workers, psychologists, community care workers, and other appropriate persons.***
d. ***The patient must have access to counselling and spiritual care services.***

The specifics of creating and administering a regulatory scheme which meets these requirements is best left to the Provinces. For example, a province might implement a “remedy team” if a patient requests assisted suicide or euthanasia, which would ensure the patient has access to all appropriate therapies and interventions that may relieve his or her suffering prior to the patient committing himself / herself to a decision of suicide.

III. A CRITIQUE OF CERTAIN RECOMMENDATIONS BY THE PROVINCIAL TERRITORIAL EXPERT ADVISORY GROUP (PTG)

It is essential to recognize that *Carter* does not positively obligate Parliament to provide unrestricted and easy access to assisted suicide and euthanasia across Canada. This fundamental misconception about the impact of the decision has led the Provincial Territorial Advisory Group into error in at least two specific areas:

i. failure to propose safeguards to protect the vulnerable, and

ii. failure to properly balance conscience rights against patient interests.

i. the PTG's failure to propose safeguards to protect the vulnerable

First, the recommendations do not provide adequate safeguards, checks, and balances which are necessary to protect vulnerable patients, despite this being required by the Supreme Court in *Carter*. Rather, the PTG offloads all responsibility for suicide-related decisions onto physicians without any substantial guidance, resources, processes, or structures.

For example, there is no requirement that a patient make a repeated request, and that there be a waiting period to ensure there is some consistency and finality to the desire for death. The PTG does not recommend a requirement that the patient be a competent adult, as required by *Carter*. The recommendations do not make adequate provisions for patients who might "shop" for assisted suicide due to mental illness or some other reason. In fact, the PTG specifically recommends against requiring an appeal process to override the decision of a doctor to refuse assisted suicide, and specifically permits patients to continue to seek further opinions. Whereas clearly a team-based approach to assess competence and consent would be superior, the PTG does not require anything more for the irreversible decision for assisted suicide than is currently done for more common and far less serious medical procedures. There is not even a recommendation that a patient requesting assisted suicide have a clear and accepted diagnosis and prognosis. Diagnostic uncertainty may be a more prevalent problem in certain regions of Canada where access to specialized medical care is more difficult to obtain.

The PTG puts forward an idealistic and simplistic version of the average doctor-patient relationship (p. 29), assuming that the doctor has both a specialist's understanding of the patient's condition and prognosis, and an intimate personal understanding of the patient's personal interests and situation. Neither of these assumptions is likely to be accurate in the average physician-patient relationship. There is no requirement for a multidisciplinary assessment process, which would be far more appropriate. There is no requirement that potentially vulnerable patients be identified, who may require more in-depth assessment. In attempting to ensure universal, easy, and streamlined access, the PTG has neglected to recommend the safeguards, checks, and balances which are necessary and required by Carter to protect the vulnerable.

ii. The PTG's failure to properly balance conscience rights against patient interests

Respecting conscience rights, the PTG rightly recognizes that physicians with moral reservations must be exempt from being forced to participate in assisted suicide. However, this does not adequately protect the conscientious objector from being complicit in what they regard to be a most serious offence against life. As such, the exemption should extend to all health care workers (e.g. nurses and pharmacists and others) who might be requested to assist in a suicide. It must also exempt physicians from being required to refer a patient for assisted suicide, as referring a patient for suicide is considered by many conscientious objectors as an unacceptable form of cooperation in the killing of a human being. Rather than requiring mandatory discussions and referrals, there could be made publically available a registry of participating physicians and institutions for self-referral by patients.

IV. CONCLUSION

The Supreme Court's decision in *Carter* delineates at least two areas in which Parliament should act when implementing its decision legalizing assisted suicide in certain limited circumstances. First, any legislation passed by Parliament must provide protection to the vulnerable. Second, it must afford protections to those who object to participating in euthanasia or assisted suicide on grounds of conscience.

The limits proposed in this submission will serve to protect vulnerable patients, bolster the trust of Canadians in their doctors and in their health care systems, and effectively balance the conscience rights of all health care providers with the rights of patients.