

Physician Assisted Dying - A Brief for the Parliamentary Committee

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Scope of this brief

The purpose of this paper is to provide the Parliamentary Committee with a better understanding of the profound implications of the judgments of both the British Columbia Supreme Court and the Supreme Court of Canada's in *Carter v. Canada* and a framework to deal promptly with the Courts' rulings.

When the Supreme Court of Canada's judgment was released on February 5, 2015, the National Post summed it up in the headline "This Ruling Changes Everything". This judgment represents a sea change in the way we think about end of life for ourselves, our loved ones.

Carter v. Canada may well be the most important human rights legal decision for the next generation. *Carter* is of particular importance to the medical profession because it represents a radical revision of what was a restriction on the ability of Canadian doctors to deliver the kind of "treatment" that their patients wanted but were prohibited from asking for. The issue is now to be recognized as focused upon patients' rights and the medical response and is removed from the old familiar platitudes about legality, ethics, morality and political expediency.

My wife was a witness in the *Carter* case. She suffers from secondary progressive multiple sclerosis. She submitted an affidavit to the Supreme Court of Canada opposing the extension of the suspension of the declaration of invalidity on behalf of the plaintiffs in the case. That affidavit is also submitted to accompany this brief.

Let me start by posing a few questions that I consider loaded and rhetorical. Can human dignity and personal autonomy be more precious to a rational individual than life itself? How many of you have actually witnesses a loved on suffering from an incurable illness that is considered irremediable? How many of you have actually considered that you yourself could end up in life, suffering from an incurable illness that is considered irremediable and interminable? What suffering person, having lost all elements of personal dignity and/or quality of life, would not want the right to ask their doctor to follow their own wishes for a humane, comfortable end of their own life? How many of you would rather die at home, surrounded by loved ones at a time of their own choice, as opposed to in a

hospital without any control over your own end of life, perhaps the most significant moment of an entire lifetime.

It is impossible to deal with the issues in a sensitive and sensible fashion without considering the very complex and detailed analysis of Justice Lynn Smith in the Supreme Court of British Columbia of some 37 volumes of evidence from virtually every point of view and jurisdiction that has dealt with the issue of physician assisted dying.

The decision of Justice Smith, a judgment that the Supreme Court of Canada adopted without exception, is over 1400 paragraphs and 261 pages in length. It is a masterpiece of balanced analysis of the evidence and arguments pro and con, describing in great detail palliative care practices, the experience of other jurisdictions, recommendations and objections from interested proponents and opponents as well as detailed and difficult legal analysis. This analysis relieves the government of any responsibility to revisit questions specifically addressed and answered in the judgment.

Justice Smith began her Reasons for Judgment by reviewing the then current state of the law and practice in Canada regarding end-of-life care. She found that current unregulated end-of-life practices in Canada — such as the administration of palliative sedation and the withholding or withdrawal of lifesaving or life-sustaining medical treatment — can have the effect of hastening death and that there is a strong societal consensus that these practices are ethically acceptable (para. 357). After considering the evidence of physicians and ethicists, she found that the “preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death” (para. 335). Finally, she found that there are qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law (para. 319).

Justice Smith also addressed the risks of a permissive regime and the feasibility of implementing safeguards to address those risks. After reviewing the evidence tendered by physicians and experts in patient assessment, she concluded that physicians were capable of reliably assessing patient competence, including in the context of life-and-death decisions (para. 798). She found that it was possible to detect coercion, undue influence, and ambivalence as part of this assessment process (paras. 815, 843). She also found that the informed consent standard could be applied in the context of physician-assisted death, so long as care was taken to “ensure a patient is properly informed of her diagnosis and prognosis” and the treatment options described included all reasonable palliative care interventions (para. 831). Ultimately, she concluded that the risks of physician-assisted death “can be identified and very substantially minimized through a carefully-designed system” that imposes strict limits that are scrupulously monitored and enforced (para. 883). These safeguards are however an issue between doctor and patient and a matter embraced by the

confidentiality of that relationship. The federal government has no role to play in the regulation of the medical profession. The Colleges that regulate the medical profession in each province must step up to the plate to ensure that doctors understand what they can and cannot do and how they can keep adequate records to protect themselves should anyone question a physician assisted death.

Terminology

Suicide is a pejorative concept. It is important to attempt to use neutral language and avoid emotionally laden or politically charged terminology such as physician-assisted suicide when discussing the issues in *Carter v. Canada*. Physician-assisted end-of-life or physician-assisted death or some other terminology is, in the view of proponents of patient autonomy, a better choice.

Jurisdiction

Parliament has exclusive jurisdiction over criminal law. The provinces exercise exclusive jurisdiction over property and civil rights in the provinces. Healthcare is traditionally seen as a provincial jurisdiction. To the extent that Parliament was to given the opportunity to consider regulating in some fashion physician-assisted dying, the decisions of the courts must be considered in the context of limitations on Canada's criminal law jurisdiction. The purpose of the Criminal Code is to prohibit criminal activity and not to regulate medical care or interfere with doctor - patient relationships.

If the government is of the view, which is the premise of this paper, that this is essentially issues relating to doctor-patient relationships falls within the rubric of healthcare regulation, medical ethics, and medical record keeping, Canada may and probably should decide that no legislative amendments to the Criminal Code are necessary at this particular time. The provinces had seized the initiative led by the province of Ontario as has the Canadian Medical Association and the individual colleges who are responsible for the regulation of Canadian doctors. These are the front line people who must administer the lawful procedures that are authorized by *Carter*.

The Federal Panel

The federal panel appointed by the Harper government some five months after the decision of the Supreme Court of Canada has come under the legitimate scrutiny and vociferous attack because of the reasonable apprehension of bias relating to the selected panelists. Two of the panelists gave evidence in the Supreme Court of British Columbia and have declared their opposition to Physician Assisted Dying at the trial of *Carter*. Their evidence was rejected by the court. The third panelist is a former Department of Justice lawyer who is now a law professor.

The survey that was ultimately and briefly made available online with no real publicity or fanfare that would attract a broad spectrum of public opinion to

answer its poorly framed questions. The Federal questionnaire was not focused on the real issues of how to administer the new permissive regime of patient autonomy involved in end-of-life decision-making. Rather, the questionnaire was loaded with emotional rather than legal issues that had already been addressed by the court in the judgments that are now law.

The Ontario/provincial Panel

The Ontario provincial panel was a much more balanced body of distinguished Canadians who have expertise relevant to the issues that become pertinent on February 6, 2016. Its survey material was made available in advance of the federal government's survey and is, evidently on a considered analysis, a much less slanted, loaded survey than the federal panel's questionnaire. The focus of its questionnaire was far more relevant to issues surrounding the doctor-patient relationship and took for granted for the most part the concepts of patient autonomy endorsed by the court. It is likely to be a far more reliable guide for any government considering what to do, if anything, on, before or after February 6, 2016.

The notion that there may be a flood of physician-assisted deaths of vulnerable people prompted by avaricious relatives or frustrated caregivers in February 2016 because the federal government has not acted is nonsensical. The notion that the government considers that it needs more time to study the issue is equally facetious. The courts have essentially done the government's work for them.

The Department of Justice lawyers who have worked on issue in the case since 2011 and who will have studied the volumes of evidence, the judgments, the reams of written arguments, the numerous interventions by interest groups in the courts below and in the Supreme Court of Canada and who are familiar with the bulk of the evidence are fully able to highlight, as does this paper, any remaining relevant issues.

Is there a need for new legislation by June 6, 2015

Because certain interest groups, whose arguments about "slippery slopes" have been discredited by reliable evidence accepted by the courts, persist in raising emotional and religious objections to physician-assisted dying.

It is the opinion of this writer that the counsel of prudence is for the government to stand back and do nothing to determine whether there is a criminal law problem associated with a Supreme Court of Canada's decision or whether the provinces have occupied the field in a manner that provides ample protection for persons who would contravene the limited exception to section 241(b) of the Criminal Code carved out by the courts.

In other words, there is no need to rush to occupy a field because of fear mongering of abuse supported only by discredited evidence and propounded by private interest groups that are not representative of the majority of Canadian society and who would ignore or marginalize the thesis accepted by the Supreme Court of Canada.

Physicians are entrusted with making life-and-death decisions in relation to patient care on a daily basis. There is a well-established oversight of their activities both in the hospital context and in private practice through various institutionalized bodies with disciplinary jurisdiction. The fear that physicians will not act cautiously, lawfully and responsibly as the new ruling pertaining to medical end-of-life care becomes operative has no support in logic or common sense. The prohibition of the Criminal Code is limited by the Supreme Court of Canada is of course a powerful deterrent to illegal conduct. There are other oversight bodies established to deal with physicians who it is feared might consider abusing what is permissible under the Supreme Court of Canada's ruling.

It is the recommendation of this writer that the government not take any precipitous action and await the collection of data as well as the response of provincial healthcare care regulatory bodies and the medical profession itself before jumping to any conclusions about the need to fill any imaginary gap in the criminal law.

What did the Supreme Court in *Carter v. Canada* (the “Decision”) decide?

Specifically, the Court adopted the trial judgment and confirmed that a Canadian law cannot prohibit a 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. The court specifically declared that the term “irremediable” does not require the patient to undertake treatments that are not acceptable to the individual.¹

What is the basis for the Court’s conclusion?

The opening paragraph of the judgment of the Supreme Court of Canada set the tone for the rest of the Court’s careful analysis.

[1] It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be condemned to a life of severe and intolerable suffering. *A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.*

The Decision provides a thorough analysis of why about section 241(b) of the Criminal Code was unconstitutional as an unwarranted interference with individual rights that could not be justified as being reasonable constraints in a free and democratic society.

¹ Paragraph 4

[63] ... [W]e do not agree that the existential formulation of the right to life requires an absolute prohibition on assistance in dying, or that individuals cannot “waive” their right to life. This would create a “duty to live”, rather than a “right to life”, and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment. The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life “is no longer seen to require that all human life be preserved at all costs” (Rodriguez, at p. 595, per Sopinka J.). *And it is for this reason that the law has come to recognize that, in certain circumstances, an individual’s choice about the end of her life is entitled to respect. It is to this fundamental choice that we now turn.*

Is a legislative response by Parliament to the Supreme Court of Canada's decision in *Carter v. Canada* (the “Decision”) either likely to be necessary or appropriate in the future?

The Court did not strike down in its entirety the criminal offense of assisting a person to commit suicide. The language of the Decision is limited to rendering inoperative the prohibition on physicians assisting their patients who meet the court’s criteria. Therefore, Parliament may leave the general prohibition in place or re-enact it with a specific exemption that is consistent with the specific language of the exemption expressed clearly in the Decision.

Because the Decision provides its own guidelines as to what is an impermissible interference with patient autonomy and Charter rights of individuals who qualify for a physician-assisted end-of-life, it would be a foolish and impermissible exercise for government attempt to determine, in legislative language, the meaning of the term “consent”, the nature of a “grievous and irremediable medical condition” or to attempt to circumscribe what causes “enduring suffering that is intolerable to the individual and the circumstances of his or her condition”. These are concepts that are best understood by patients who would consider requesting a physician-assisted death and by doctors who are experienced in the treatment of their patients.

The Court observed that doctors determine consent and the capacity to give consent on a daily basis. Canada does not need a committee to make that determination and the interposition of any barrier that would interfere with the normal doctor-patient communication whereby patients consent to treatment and doctors provided such treatment is likely unconstitutional and inconsistent with both the spirit and the letter of the Decision.

The Court noted:

[90] The trial judge concluded that the prohibition’s negative impact on life, liberty and security of the person was “very severe” and therefore grossly disproportionate to its objective (para. 1378). We agree that the impact of the prohibition is severe: it imposes unnecessary suffering on affected individuals, deprives them of the ability to determine what to do

with their bodies and how those bodies will be treated, and may cause those affected to take their own lives sooner than they would were they able to obtain a physician's assistance in dying. ...

[106] The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process (paras. 795-98, 815, 837 and 843). In reaching this conclusion, she particularly relied on the evidence on the application of the informed consent standard in other medical decision-making in Canada, including end-of-life decision-making (para. 1368). She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity (para. 831).

[107] As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying (paras. 852 and 1242). She thus rejected the contention that unconscious bias by physicians would undermine the assessment process (para. 1129). The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization (para. 731). She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized: para. 1271. Finally, she found no compelling evidence that a permissive regime in Canada would result in a "practical slippery slope" (para. 1241).

[109]We see no reason to reject the conclusions drawn by the trial judge. They were reasonable and open to her on the record.

Can Parliament mandate a cooling-off period to enable a patient who otherwise qualifies the opportunity to change his or her mind?

The illusory "slippery slope" is the argument that opponents of physician-assisted dying have been raising for years and continued to raise both in the trial court and in the interventions permitted in the Supreme Court of Canada. It was a foundation of the federal government's opposition to the constitutional challenge and an alleged foundation for their argument that the probation against physician-assisted dying was justified in a free and democratic society. As noted above, the both the trial judge and the Supreme Court specifically rejected the

boogyman of the “slippery slope”. They agreed with the trial judge that there was “no compelling evidence that a permissive regime in Canada would result in a “practical slippery slope”.

According to the Court's decision, a patient who is enduring intolerable suffering has the right to immediate rather than a deferred treatment to end that suffering. Take for example situation of a patient who has suffered massive injuries or extensive, excruciating burns, who is unable physically to take their own life and who requests his or her physician to end the patient's suffering by a lethal injection.

There is nothing in the judgment of either Court that would support the proposition that government can deprive a subject their constitutional right for a period of time by legislating that patient must endure for a cooling off period of 30 days. There is no constitutional basis for the suspension by a legislature of an individual patient's *Charter* rights. The judgment of the court was that a person who is suffering from bone cancer or other excruciating, painful conditions has the right to determine the manner and mode of their death. Numerous passages in the Decision made clear that it would be impermissible for Parliament to legislate an arbitrary cooling-off period. The following are but two such passages:

[67] The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the “tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity” (para. 39). This right to “decide one's own fate” entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of “informed consent” and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.)). *As noted in Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), *the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision*. It is this 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 or discontinued: see, e.g., *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.).

[68] In *Blencoe*, a majority of the Court held that the s. 7 liberty interest is engaged “where state compulsions or prohibitions affect important and fundamental life choices”: para. 49. In *A.C.*, where the claimant sought to refuse a potentially lifesaving blood transfusion on religious grounds, Binnie J. noted that we may “instinctively recoil” from the decision to seek death because of our belief in the sanctity of human life (para. 219). But his response is equally relevant here: *it is clear that anyone who seeks physician-assisted dying because they are suffering intolerably as a result*

of a grievous and irremediable medical condition “does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live” (ibid.). The trial judge, too, described this as a decision that, for some people, is “very important to their sense of dignity and personal integrity, that is consistent with their lifelong values and that reflects their life’s experience” (para. 1326). This is a decision that is rooted in their control over their bodily integrity; it represents their deeply personal response to serious pain and suffering. By denying them the opportunity to make that choice, the prohibition impinges on their liberty and security of the person. As noted above, s. 7 recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life. We therefore conclude that ss. 241(b) and 14 of the Criminal Code, insofar as they prohibit physician assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, infringe the rights to liberty and security of the person.

Does illness or suffering have to be at the end of life in order to for a person to qualify for a physician assisted death?

The Court answered that question clearly as well. For the same reason that it would be a violation of the Charter to legislate a cooling off period, the Court determined that Parliament does not have the right to determine who shall be forced to live and when the right to make that choice arises. The only qualifications for a physician-assisted death are:

- Competence
- Adulthood
- A grievous and irremediable medical condition
- Enduring and intolerable suffering caused by the medical condition.

Adulthood is an objective fact defined by provincial legislation. Determining competence as the Court noted in paragraph 106 of the Decision is a medical issue left to physicians. Again, I quote:

[106] The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process (paras. 795-98, 815, 837 and 843). In reaching this conclusion, she particularly relied on the evidence on the application of the informed consent standard in other medical decision-making in Canada, including end-of-life decision-making (para. 1368). She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions

aimed at reducing pain and avoiding the loss of personal dignity (para. 831).

Similarly, Parliament cannot define what is a grievous and irremediable medical condition. That is a medical determination. Moreover, the Court made it clear that the issue of what is enduring and intolerable suffering is a subjective matter within the competence of the patient, not the doctor and not Parliament, stating that the suffering that gives rise to the right to a physician assisted death is suffering *“intolerable to the individual in the circumstances of his or her condition”*.

It is to be noted that the Supreme Court of Canada made specific reference to the situation of the plaintiff Gloria Taylor at the time of the trial was suffering from ALS. There was no evidence that her prognosis would lead to her imminent death. Finally there was the case of other witnesses such as Elayne Shapray and others referred to in various places of the trial judgment who were not suffering from an illness that is “terminal” but who were unable, because of their disability, to take their own lives. Elayne Shapray suffers from progressive multiple sclerosis, which is a totally debilitating but not a terminal illness. The trial judge found that such persons were, if they otherwise qualified, constitutionally entitled to a physician-assisted death as much as persons who had a terminal illness.