Protecting Patients and Doctors: The *Charter* Rights of Medical Practitioners

Brief to the Special Committee on Physician-Assisted Dying

February 1, 2016

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Recommendation 1: The new federal legislation should provide explicitly that physicians, nurses, pharmacists, and other health care workers, as well as health care organizations and institutions, can refuse to participate in, and refuse to refer for, physician-assisted suicide ("PAS") or euthanasia.

The Supreme Court of Canada decision in *Carter v. Canada (Attorney General*), [2015] 1 SCR 331 ("*Carter"*) in no way compels doctors or other healthcare workers to cooperate unwillingly in a PAS. *Carter* was predicated on two key factual conditions: a willing patient and a willing doctor. The applicants in *Carter* all had willing doctors. They neither sought nor received a *Charter* right to compel doctors and other healthcare practitioners to provide, or refer for, PAS.

The *Carter* ruling does not positively obligate physicians or anyone else to add assisted suicide or euthanasia to their medical practices. The *prohibition* against PAS has been struck down as a violation of s. 7 of the *Charter*, but this does not confer on patients a *right* to require an unwilling doctor to assist with a suicide. The existence of a "right" of patients to require every physician to refer for every medical service is a misconception that some of the provincial Colleges of Physicians, as well as the Canadian Medical Association, appear to be operating under.

Many doctors and other healthcare workers object to assisted suicide and euthanasia on the grounds of ethics, morality and conscience, whether based on an identifiable "religious" principle or not. Others object as a matter of professional ethics, which is no less an objection of conscience. In *Carter*, 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."[1] Appropriately, the Court deferred to Parliament and the provincial Legislatures to implement a scheme which recognizes the *Charter*-protected conscience rights of physicians, nurses, pharmacists, and other health care providers.

Parliament should explicitly affirm in legislation 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, including referral. Parliament should affirm that the failure to so participate or refer does not infringe the rights of patients, and is not a reason for discipline or other sanction, either criminal, civil or professional.

Foundational principles concerning freedom of religion were laid down by the Supreme Court of Canada in *R. v. Big M Drug Mart Ltd*.,[2] and have been repeatedly affirmed in subsequent rulings:

> A truly free society is one which can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs and codes of conduct. … The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of

[1] *Carter* at paras. 130-132.
[2] *R. v. Big M Drug Mart Ltd*., [1985] 1 SCR 295 at 336-37 [*Big M Drug Mart*].

> hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination. But the concept means more than that.
>
> Freedom can primarily be characterized by the absence of coercion or constraint. *If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free.* … [C]oercion includes indirect forms of control which determine or limit alternative courses of conduct available to others…
>
> *What may appear good and true to a majoritarian religious group, or to the state acting at their behest, may not ... be imposed upon citizens who take a contrary view. The Charter safeguards religious minorities from the threat of "the tyranny of the majority*". [Emphasis added]

Medicine is one of many public spheres in which an individual can choose to work. The fact that a person provides services to the public, and the fact that some or all of those services are paid for directly or indirectly by government, does not remove *Charter* protection from individuals who serve the public. In particular, a person providing services to the public does not lose her *Charter* section 2(a) freedom of conscience and religion.

Recommendation 2: Parliament should enact legislative protections for medical practitioners in a substantially similar fashion to those contained in the *Civil Marriage Act*.

There is clear precedent for the protection of conscience rights for public service providers on the grounds of conscience and religion.[3] In the *Civil Marriage Act*, SC 2005, c 33, specific protections were enacted for individuals and organizations who have a religious or moral belief that marriage is between a man and a woman to the exclusion of all others. Consequently, religious officials cannot be sanctioned or prosecuted for refusing to perform a same-sex marriage. Likewise, registered charities which believe in marriage as the union of one man and one woman are not at risk for adhering to, and advocating for, this belief. No citizen can be sanctioned for expressing the belief that marriage is between a man and a woman. These commonly held beliefs and their expression are not against the public interest.[4]

The same types of protections are necessary for medical practitioners in the wake of the *Carter* decision. In addition to protections for refusing to participate or refer for PAS, there should be no sanction or professional or legal penalty against medical practitioners for holding or voicing an opinion in regards to the ethics or morality about PAS. Similarly, such beliefs and their expression are not against the public interest.

[3] To the grounds of conscience and religion we would add ethics as a protected ground to refuse to participate or refer in a physician assisted suicide.
[4] *Civil Marriage Act*, SC 2005, c 33, preamble and ss. 3 and 3.1.

As affirmed by the Supreme Court of Canada in *Carter*: "Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic."[5] In this way, the issue of physician-assisted suicide is analogous to that in the *Civil Marriage Act.* Since Parliament enacted conscience protections when legislating same-sex marriage it should do so when legislating assisted suicide.

Recommendation 3: The new federal legislation should mandate that the Application process for PAS be made to a Superior Court Judge on a permanent basis, as already established on an interim basis by *Carter*. Of all the available options to Parliament this is the best.

Parliament has a number of options it could legislate to implement the Court's decision in *Carter*. Of the several options, such as the establishment of a national review board to conduct the application process for PAS, or leaving the approval process with physicians on a case-by-case basis, the appropriate and most logical course is to permanently codify that applications for PAS continue to be made to a Superior Court Justice.

This option has several advantages.

First, judges are schooled in the law and the Constitution. A Justice can make educated decisions about any potential conflict between provincial and federal health legislation. A judge has jurisdiction to review both types of legislation and is trained and experienced to deal with Constitutional arguments. Justices are better equipped to handle the kinds of legal issues that may arise, as opposed to the alternate scenario where applications for PAS were made, for example, to a national review board.

Second, judges of the Superior Courts have far-reaching powers to order hearings, require evidence and require the attendance of witnesses. They can also give justice on a timely basis, as they are regularly available in provincial jurisdictions.

Third, a judge is better equipped to weigh the many issues than attending physicians. Attending physicians' opinions are important, and federal legislation should mandate that two supporting Affidavits from physicians familiar with the Application for PAS be submitted to the Court. Aside from being schooled in the law and the Constitution, a judge cannot be sued for malpractice. If physicians were permitted to make the final decision on who was qualified for PAS pursuant to the *Carter* criteria, it would unnecessarily expose physicians to potential civil and criminal prosecution. There could be malpractice insurance ramifications.

Fourth, a judge is more equipped to deal with the inevitable competing claims and hostilities between family members, or alternatively, cases where a patient may be under duress from a family member to commit PAS. These types of issues should not be placed on the shoulders of physicians.

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[5] *Carter* at para. 53.

Finally, having a judge hear Applications for PAS largely removes the likelihood of doctor-shopping in the event a patient receives a "no" to a PAS request. While the majority of doctors are doubtless scrupulous individuals there are doubtless some who are substantially less likely to properly investigate requests for PAS, just as there are some who are far more likely to improperly prescribe medication upon request. This is highly inappropriate in the context of medication but it is unthinkable in the context of PAS.

Recommendation 4: The new federal Legislation should mandate a Parliamentary Review Board every 3-5 years to review the physician-assisted suicides that have occurred, and make recommendations for any legislative amendments.

The Supreme Court in *Carter* rejected the argument that the federal regulation of physician-assisted suicide infringes the "protected core" of provincial health care.[6] The limit of each jurisdictions' reach has not been precisely determined.[7] Health care is a matter of concurrent jurisdiction in Canada, and both the federal government and the provincial governments may pass valid legislation in regards.

The benefits of a Parliamentary Review Board (as opposed to a new national review board) are apparent. First, a new bureaucracy is likely to have issues with the enforcement of data collection and reporting vis-à-vis the provinces. It would be difficult to bestow the requisite investigative powers on a national bureaucracy. Consequently, the body would be obliged to review only what was submitted to it. This would not be case with a Parliamentary body, which has the ability to issue subpoenas and otherwise conduct the necessary investigations. Parliament can order its own *a priori* review on whatever terms it desires, and it will be assured of compliance.

Second, the establishment of yet another bureaucratic body is a poor use of taxpayer funds in what are already challenging economic times. A national review board would only be established to do what a Parliamentary Review Board is already capable of doing. Moreover, a national review board would have little or no authority over the provinces. Canada does not need another independent body established for the sole purpose of having its own opinion.

Third, a national review board would not be comprised of individuals who are responsible to the electorate. This is not the case with Parliament. This adds an additional level of accountability that is a requirement for issues of life and death.

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[6] *Carter* at paras. 51-53.
[7] *Carter* at para. 53.

The codification of such a Parliamentary Review Board is essential for both for compliance review as well as for statistical purposes. The analysis of such data would prove integral to future legislative amendments.

The Moral Practice of Medicine

The Hippocratic Oath is one of the most well-known Greek texts which survive to the modern era. It was sworn by all physicians prior to embarking on the practice of medicine, with all of its sacred, moral and ethical obligations. Amongst other moral and ethical covenants (patient confidentiality, requisite skill, never to attempt to seduce a patient etc.), the Hippocratic Oath required a physician to swear not to give anyone poison, "nor counsel any man to do so."[8]

The Hippocratic Oath has been adapted over time, but its moral and ethical principles continue to influence oaths of medical professions in jurisdictions around the world today. The Physician's Oath in the Declaration of Geneva is one example of the importance of morality and ethics to the practice of medicine:

> I solemnly pledge to consecrate my life to the service of humanity;
> I will give to my teachers the respect and gratitude that is their due;
> I will practise my profession with conscience and dignity;
> The health of my patient will be my first consideration;
> I will respect the secrets that are confided in me, even after the patient has died;
> I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
> My colleagues will be my sisters and brothers;
> I will not permit considerations of age, **disease or disability**, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; [Emphasis added]
> **I will maintain the utmost respect for human life**; [Emphasis added]
> I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
> I make these promises solemnly, freely and upon my honour.

The Declaration of Geneva is based on the grave concerns arising from the purely experimental use of medical knowledge and training during the Second World War by Nazi Germany and Imperial Japan, unhinged from guiding values of religion, ethics, and morality.

The history of medical oaths serves to illustrate that there is an ancient and near-universal acknowledgement that profound moral and ethical obligations rest on physicians, and indeed on all medical practitioners. Those practitioners should be encouraged to continue to acknowledge such obligations, rather than being threatened with sanctions for doing so. Respect for moral and ethical considerations must be preserved, to prevent the erosion of the values of the medical profession.

[8] [https://books.google.ie/books?id=Oe0EAAAAQAAJ&pg=PA258&hl=en#v=onepage&q&f=false]

It is important for Parliament to remember that, while the prohibitions against PAS and euthanasia have been erased from the *Criminal Code* by *Carter*, the history of medicine and its associated ethical obligations have not been erased from the hearts and minds of medical practitioners.

Recommendation 5: Parliament should note the constitutional infringements already apparent in the various guidelines released by the provincial Colleges of Physicians and the Canadian Medical Association, and codify the necessary protections in the pending legislation to prevent the erosion of practitioners' rights.

On January 16, 2016, the Canadian Medical Association ("CMA") released its "Principles-based Recommendations for a Canadian Approach to Assisted Dying" (the "Principles"). While the CMA appears to have made significant progress towards properly protecting the rights of physicians, specific Principles are excerpted to illustrate some remaining potential constitutional problems.

> ***Respect for persons**: Competent and capable persons are free to make informed choices and autonomous decisions about their bodily integrity and their care that is consistent with their personal values, beliefs and goals.*

This Principle refers to the capacity of the terminally ill to self-govern. However, while a patient may be competent to formulate a desire to die, they may be impotent to carry it out. The words "capable" and "autonomous" are inseparable from notions of self-reliance and independence. The dependence of an incapable patient necessarily calls into question the rights of any assist-or. A proper and constitutional approach to PAS will be balanced[9] and will not disproportionately favour the right of a patient over that of a physician.

> **Respect for physician values**: *Physicians can follow their conscience when deciding whether or not to provide assisted dying without discrimination. This must not result in undue delay for the patient to access these services. No one should be compelled to provide assistance in dying.*

In contrast with the College of Physicians of Ontario's position on referral, there is much to be applauded in the recently-released CMA draft guidelines against mandatory referral. The CMA has stated that, "the argument that only mandatory referral puts patients' interests first or respects patient autonomy − and that not making a referral does not − is fundamentally erroneous."[10]

However, the CMA appears to qualify the right of conscience on the ground of delay, as though a moral or ethical objection expires with the passage of time, or can be overridden if a patient considers it inconvenient.

For many physicians, nurses, pharmacists, and other medical practitioners, being compelled (whether eventually or immediately) to refer a patient to a physician who will subsequently kill

[9] *Carter* at para. 98. A flawed PAS system will be more subject to challenge than the recently-struck prohibition.
[10] See, for example: [http://consciencelaws.org/background/policy/associations-013.aspx]

the patient constitutes a serious violation of conscience, and of the moral and ethical principles in which conscience is grounded.[11] Consider the following scenario:

> **Physician:** I understand that you are interested in physician assisted suicide. I cannot personally perform that option for you, nor can I refer you to someone who can, due to my ethical and moral convictions on the subject.
>
> **Patient:** What do you mean, moral convictions, I don't understand.
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> **Physician:** I'll explain. I believe that I have a sacred obligation as a physician to guard life as part of my profession. One of the passages in the ancient Hippocratic oath reads thus: "Nor shall any man's entreaty prevail upon me to administer poison to anyone; neither will I counsel any man to do so." I take the history of my profession seriously, and I choose to abide by those precepts. Consequently, in my view, it would be contrary to my moral and religious obligations to assist a patient to deliberately end his life.
>
> **Patient**: Spare me your moral qualms. You are not in the pain I am in, and I didn't ask to be preached to. I want to speak to your superior. I am aware that you are required to refer me under the new guidelines. You have no choice.

If health care providers are required to refer for physician-assisted suicide, then an honest and sincere conversation as the one above can result in doctors being disciplined for adhering to their moral and ethical beliefs.

> ***Clarity:*** *All Canadians must be clear on the requirements for qualification for assisted dying. There should be no "grey areas" in any legislation or regulations*

The Principle of clarity is a laudable goal, but it can only be achieved if the rights of medical practitioners are clearly articulated in the pending legislation. If rights are not clarified, grey areas will be inherent, and disciplinary proceedings will be commenced against "offending" physicians, who could then be forced to choose between their conscience and their careers. As a prime example, the words "grievous and irremediable" in *Carter* as the criterion for justifying PAS remain undefined. Due to the ambiguity in the criteria, it is currently inevitable that unintended results will occur. Parliament must take this opportunity to define these terms.

> ***Solidarity:*** *Patients should be supported and not abandoned by physicians and health care providers, sensitive to issues of culture and background, throughout the dying process regardless of the decisions they make with respect to assisted dying.*

The ninth Principle of the CMA is that of solidarity. This is a further example of the imbalanced approach taken to the question of the rights of a patient and the right of a medical practitioner. This principle fails to distinguish between "dying" and "suicide". Physician-assisted *dying* is as old as the practice of medicine itself, and today is known as palliative care. Neither Physician's Oaths nor the *Criminal Code of Canada* have stood in the way of "assisted dying", but "assisted

[11] This is especially true where a patient may desire PAS when therapies that have been rejected by the patient would or are likely to improve a patient's prognosis: *Carter* at para. 127.

suicide" and other forms of deliberate and active killing are a different matter altogether. It is not difficult to foresee examples where a positive requirement for a physician to support a patient's decision "no matter what" could quickly violate a physician's *Charter*-protected conscience rights.

In practice, it is difficult to envision any scenario in the real medical world where a physician would be called upon to support a patient's decisions "no matter what." Physicians routinely disagree with, and withdraw their support from, a patient's decisions on a vast number of less significant medical decisions, ranging from a patient refusing to take medication to a patient refusing to exercise, to a patient refusing treatment. Why should a doctor's right to be a doctor (an honest counselor and a medical professional) in a PAS situation be any different?

Recommendation 6: Parliament should prohibit the use of advance directives for PAS to protect the vulnerable.

Many parties before this Honourable Committee have advocated for legislative authorization for the use of advance directives for PAS or euthanasia. It is argued that the ability to utilize an advance directive would permit a competent person to declare the physical circumstances upon which they wish to be euthanized, and that this is desirable. This position is not only incompatible with *Carter*, it has intrinsic unresolvable ethical dilemmas, and for this reason must be rejected.

First, *Carter* makes no provision for the use of advance directives for euthanasia or PAS. Carter speaks of a decision made by a competent adult person who is at the time suffering in a "grievous and irremediable" manner.[12] These criteria rule out the use of personal directives for PAS.

In issuing the remedy in *Carter*, the Court held as follows:

> The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are 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.

The Court used the words "consents", "has", "causes" and "is" to describe the permissible criteria for when a person could avail themselves of PAS. These pronouns are all "present tense" – there is no contemplation by the Court of a possible eventuality, such as that described in an advance directive. There are several obvious reasons for this.

First, people change their minds. It is impossible for one to know precisely or accurately how one will feel if a given circumstance transpires, and in the event that one becomes "incompetent" it would be impossible to determine whether a person has changed her mind. There are people with dementia and other illnesses who nevertheless gain enjoyment from life.

[12] *Carter* at paras. 3, 4, 127.

Second, if a person had been under duress at the time of the execution of the advance directive it would be impossible to determine duress in the event that a person became mentally incompetent. It would be profoundly naïve and negligent to ignore the potential for abuse advance directives provides self-serving relatives.

In both of the above foreseeable and inevitable scenarios, PAS would be nothing less than state-assisted murder.

Both scenarios are unresolvable. Therefore, advance directives for PAS must be legislatively prohibited.

The Weighing of Rights

Some people argue that ensuring a patient has access to all legal medical procedures is a sufficiently pressing and substantial objective to justify violating physicians' conscientious and religious rights. However, the fact remains that patients do not have a *Charter* right to obtain from *every* physician whatever medical service or referral they may desire. Conversely, physicians *do* have a *Charter* right to act on, and be guided by, their moral, ethical and religious beliefs, without this freedom being violated by a government body. The same applies to the provision of any other service. A law may provide individuals with the freedom to pursue an activity or course of action, but that is radically different from a law that requires others – on pain of sanction or adverse consequence – to assist (directly or indirectly) an individual in carrying out that legal activity or course of action.

The direct violation of many physicians' *Charter* freedom of conscience and religion outweighs the benefits, if any, that may result from requiring **all** physicians to refer for life-ending or other controversial treatments. In the relevant context, i.e. in which controversial medical services are made available for those who desire them, there is no rational connection to support a requirement that **every** doctor be available to perform, or refer for, every health service.

Government bodies should promote and encourage the ability of physicians to practise medicine with a clear conscience. Creating an artificial line in medical practice between the required "clinical" and the optional "moral" (which can be, but need not be, informed by religious beliefs) is misguided if not dangerous. Science can inform physicians as to what dosage of which drug will end the patient's life. However, science or "clinical considerations" provide no guidance as to whether killing a patient, or helping a patient commit suicide, is right or wrong, or under what conditions. A physician who is guided only by science, to the exclusion of conscience and ethics, could be seen by terminally ill patients and their families as inherently untrustworthy.

Conclusion

The recognition of fundamental rights, such as those of conscience and religion in Canada, pre-date the *Charter*. Since 1982 they have been enshrined in the *Charter* as part of the Constitution of Canada. The Constitution is the supreme law of the land, and the activities of the legislature, past, present and future, must conform to it.

In the PAS scenario, the rights of objecting medical practitioners supersede the rights of those who wish to die by PAS.[13] *Nothing* in the *Carter* decision requires an objecting doctor to take part in an action that is against his or her conscience, irrespective of what the various Colleges of Physicians or the CMA purport to require. If Parliament appropriately balances the rights at play and establishes a nuanced system in conjunction with the provinces, the Courts will give it a high degree of deference if the new law is challenged as violating *Charter* rights.[14] The challenge for Parliament is to properly codify and protect the rights at issue.

We therefore make the following five recommendations for the pending legislation:

- Recommendation 1: The new federal legislation should provide explicitly that physicians, nurses, pharmacists, and other health care workers, as well as health care organizations and institutions, can refuse to participate in, and refuse to refer for, physician-assisted suicide ("PAS") or euthanasia.

- Recommendation 2: Parliament should enact legislative protections for medical practitioners in a substantially similar fashion to those contained in the *Civil Marriage Act*.

- Recommendation 3: The new federal legislation should mandate that the Application process for PAS be made to a Superior Court Judge on a permanent basis, as already established on an interim basis by *Carter*. Of all the available options to Parliament this is the best.

- Recommendation 4: The new federal Legislation should mandate a Parliamentary Review Board every 3-5 years to review the physician assisted suicides that have occurred and make recommendations for any legislative amendments.

- Recommendation 5: Parliament should note the constitutional infringements already apparent in the various guidelines released by the provincial Colleges of Physicians and the Canadian Medical Association, and codify the necessary protections in the pending legislation to prevent the erosion of practitioners' rights.

- Recommendation 6: Parliament should prohibit the use of advance directives for PAS to protect the vulnerable.

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[13] *Carter* at para. 132.

[14] *Carter* at paras. 97 and 98.

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The free and democratic society which the *Canadian Charter of Rights and Freedoms* holds out as our ideal can only be fulfilled by honouring and preserving Canada's rich and strong traditions of freedom of speech, freedom of religion, freedom of association, private property rights, constitutionally limited government, the equality of all citizens before the law, and the rule of law. And yet these core principles of freedom and equality continue to be eroded by governments and by government-funded and government-created entities such as universities and human rights commissions.

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