

Montréal, 31 January 2016

Ms. Cyrana Corbin  
Ms. Shaila Anwar  
Joint Clerks  
Special Joint Committee on Physician-Assisted Dying  
[PDAM@parl.gc.ca](mailto:PDAM@parl.gc.ca)

Dear Ms. Corbin & Ms. Anwar:

I am submitting this brief as a private individual, in my capacity as a physician, philosopher and Canadian citizen. I would ask that the context of my particular interest in the issue of physician-assisted dying be taken into account, however, as it could have some bearing on the Committee members' reading and understanding of my brief.

In the last 15 years, I worked as an ethics advisor to the directors of the Collège des médecins du Québec [Quebec college of physicians and surgeons] and secretary to the CMQ's working group on clinical ethics. For more than a decade, therefore, I was intimately acquainted, through my work, with the debate on this subject in the province of Quebec. Indeed, the CMQ began looking at this issue in 2005, quite some time before the matter fell into the public eye, and the CMQ continues to be an active player with regard to the enforcement of Quebec's *Act Respecting End-of-Life Care*.

Although I left these duties with the CMQ in April 2015, my interest in this subject has not waned by any means.

I feel the need to express my views on this subject because it is clear to me that the task you have been asked to perform will be very difficult. How can you possibly get a full grasp of such complex issues in only a few weeks? It would be gratifying to know that all of the energy I invested to acquire an understanding of these issues could be of some use to you and will not go to waste. Of course, my views are biased to some degree, but that can be said of all views.

I hope the contents of my brief will serve to enlighten you further.

Sincerely,

Michèle Marchand, M.D., Ph.D.

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Will “physician-assisted dying” become one more reason  
to want Quebec independence?

Brief Submitted to the  
Special Joint Committee on Physician-Assisted Dying  
by  
Michèle Marchand, M.D., Ph.D. (Philosophy)

31 January 2016

## **Will “physician-assisted dying” become one more reason to want Quebec independence?**

The longer we take to give effect to the Supreme Court decision on “physician-assisted dying,” the more confusion swirls around this concept. This would not be such a serious concern if the confusion was strictly terminological; however, the spread of confusion seems to be affecting even the ideas that took years to clarify in the province of Quebec.

In my opinion, there is an urgent need to reaffirm as clearly as possible what was a matter of consensus in Quebec and to admit humbly that some issues were not resolved because they are inherently more difficult to address. The need is particularly urgent in light of the fact that the government is moving to address these issues in Ottawa and that only a short time has been set aside to debate these matters.

### **1. In Quebec: extensive public debate, a measure of consensus and legislation concerning end-of-life care**

Let us start with a brief review of historical facts. Following lengthy consideration of the intensity of care and the decision-making process, Quebec physicians indicated that they were somewhat receptive to the idea of actively providing aid in dying to end-of-life patients whose suffering could not readily be relieved. This was in 2009. The broad public debate that followed resulted in a certain degree of consensus, which in turn led, five years later, to the passage of a bill by the National Assembly concerning not just “medical aid in dying” but indeed all end-of-life care. Quebec’s *Act Respecting End-of-Life Care* came into force on 10 December 2015. Thus, within the province of Quebec, the picture was relatively clear until recently.

#### **1.1 Yes, we want physicians to be able to assist end-of-life patients in dying**

The *Act Respecting End-of-Life Care* adopted by the Quebec National Assembly on 10 June 2014 is clear. It defines “medical aid in dying” to mean “care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient’s request, in order to relieve their suffering by hastening death.” Since 10 December 2015, when the legislation came into force, the criteria for eligibility to obtain medical aid in dying are essentially as follows: a patient must be an insured person within the meaning of the *Health Insurance Act*, be of full age and capable of giving consent to care, be at the end of life, suffer from a serious and incurable illness, be in an advanced state of irreversible decline in capability, and experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

The goal is precise and, all in all, fairly restrictive: to make it possible for physicians to aid patients facing inevitable and relatively imminent death to avoid needless suffering, in exceptional cases where symptoms are extremely difficult to relieve. Nevertheless, the debate

surrounding this issue was marked by clear disagreements – and for good reason. Whatever terms are used, the establishment of a new exception to the prohibition on causing the death of a human being is not a trivial matter.

Arguably, it became possible to reach a consensus despite these disagreements because medical aid in dying was considered a form of care and framed as such. Social solidarity and compassion therefore prevailed, although autonomy remained a key consideration. Not only must the individual concerned consent to such care, he or she must in fact request it. Physicians are required to follow a very strict protocol for validating and, if necessary, giving effect to such a request.

At the risk of seeming harsh, it is important to be crystal clear here. Once the decision has been made, protocol calls for the end of life to be hastened as respectfully and efficiently as possible. For this reason, it was agreed that specific, fast-acting and inevitably lethal substances must be administered by injection by a physician and not prescribed as a medication to be taken by a patient at a time of his or her choosing, with the risks of complications and failures that would entail.

No one ever claimed that sufficient consensus was achieved to put an end to the debate. The fact remains that many people, including a number of physicians, continue to be opposed to this practice. The legislation in fact shows great respect for the right of health care workers to conscientious objection. It is also clear that the legislation leaves open the question of medical aid in dying for persons who are incapable of giving consent or who have not reached the end-of-life stage.

## **1.2 No, we are not ready to provide medical aid in dying to non-end-of-life patients**

As debate on the issue was drawing to a close in Quebec, the Supreme Court of Canada announced its decision in *Carter v. Canada* concerning a dispute over a request for assisted suicide by an individual who was not yet an end-of-life patient. In the decision released on 6 February 2015 the Court invalidated the provisions of the *Criminal Code* prohibiting all forms of assisted dying and considered that medically assisted suicide and euthanasia should be available under certain conditions that are essentially the same as those specified in Quebec's *Act Respecting End-of-Life Care*, save for the requirement that individuals must be at the end of life.

This may appear to be a minor difference, but it most assuredly is not. In my opinion, it completely changes the picture and the moral issues at play. Hastening the death of a person whose life is drawing to a close in any case is an action that does not carry the same moral weight as hastening the death of a person who believes that life is no longer worth living.

I do not believe there are many people, let alone physicians, willing to assume the moral burden of assisted suicide. I am far from certain that our societies would wish to assign such a

responsibility to physicians or even promise these individuals assistance in dying because they have chosen to end their lives. For some people, autonomy is a value that can eclipse all other considerations. It seems to me that, here too, social consensus leans toward compassion and solidarity which, in this instance, tend to want to help these individuals give new meaning to their lives.

Once again, let us be clear. Suicide is no longer prohibited in Canada, but it is a huge leap to go from there to assisted suicide – a leap that Quebec was unwilling to make.

### **1.3 We chose to patiently reflect upon how best to assist these people and upon what comes next**

In my view, the decision not to open the door to assisted suicide was the right decision. But I don't believe we can stop there. For some suffering individuals, the promise that medical assistance will be provided at the end of life will not be enough, and they will not depart from their decision to shorten their lives regardless of all of the support made available to them. So how can we help these people?

The answer may be elsewhere. More and more cases are now being reported of people wishing to shorten their lives not asking for physicians to aid them in their quest, even in jurisdictions where this is permitted. Instead, they are refusing treatment or, if they are not under active treatment, they are refusing to eat and drink. Nowhere is the right to demand certain types of care guaranteed; however, the right to refuse care has long been recognized in Quebec and elsewhere. Nutrition and hydration, even natural, are recognized forms of care. A person who is of age and capable of giving consent to care therefore is entitled to refuse certain types of care, even if such care is essential to the preservation of his or her life. Health care workers must respect this decision and see to the comfort of the patient, which they are perfectly capable of doing. Health care personnel are ultimately called upon to “help persons to die,” but this does not constitute “assisted suicide” – much less “euthanasia” – in the generally accepted sense of those terms.

Such a continued refusal of medical care would be entirely consistent with the spirit of the Quebec legislation. Indeed, the entire second part of the Act is devoted to advance medical directives and to respecting the wishes of the people concerned. It is clearly stated that provisions respecting advance medical directives and patients' wishes apply to all medical care, regardless of whether the individuals in question are at the end-of-life stage. Other paths could open up, since the Act establishes a commission on end-of-life care that may, based upon the mandatory reports filed by physicians for all such requests, compile essential data to fuel ongoing debate on this issue.

## **2. In Canada: Obligation to legislate in the wake of the Supreme Court decision**

Obviously, the waters were muddied by the Supreme Court decision that found the complete prohibition of assisted dying to be unconstitutional and required the federal and provincial

governments to pass legislation within a relatively short period of time to legalize medical euthanasia and medically-assisted suicide, subject to certain conditions specified by the Court. The strange turnaround by the organizations representing physicians in the rest of Canada indicates an apparent willingness to accommodate such a drastic change in situation. But from Quebec's standpoint, it is as though the entire process had to be repeated very quickly and entirely in reverse.

## **2.1 The strange about-face by physicians, and conscientious objections**

As we have seen, the Supreme Court decision represents a startling reversal in that it opens the door to both euthanasia and physician-assisted suicide for persons of full age and capable of giving consent who are ill and suffering but have not necessarily reached the end-of-life stage of their lives. Nevertheless, everyone seems to want to back this position, starting with the organizations that represent physicians in this country. By what miracle could we expect to achieve such a consensus in only a few months, whereas Quebecers took more than five years to reach a far less stringent compromise?

This question is all the more pertinent when one considers how often the Canadian Medical Association (CMA) had previously reiterated its firm opposition to all forms of physician-assisted dying. Even when the debate was at its heaviest in Quebec, the CMA did not waver, except to consult its members again and to conclude that the majority of comments were opposed to any opening up on this issue. But now the CMA has released a document addressing recommendations to the bodies responsible for giving effect to the Supreme Court decision. Surprisingly, this document repeats almost verbatim the criteria laid out by the Court for obtaining medical aid in dying. It merely clarifies the terms employed by the Court, and the only noticeable trace of opposition concerns conscientious objections. The College of Physicians and Surgeons of Ontario recently submitted a nearly identical proposal to the attention of its members and the public, requesting their comments. A considerable number of comments were received and are available online for consultation. However, not many comments focused on the meat of the debate. Instead, the matter of conscientious objection came up repeatedly, with many physicians objecting to the new obligation that would be placed upon them of transferring the patient if their personal convictions prevented them from fulfilling a request for physician-assisted dying.

What explanation is there for this about-face? I don't believe in miracles. I think that physicians, whose collaboration was taken for granted by the Supreme Court, have simply abdicated collectively and now see conscientious objection as the only way out left to them. You don't have to be a prophet of doom and gloom to predict an increase in the number of conscientious objections, which is something we sought to avoid in Quebec by making certain we had the cooperation of physicians throughout the process. Of course, this was made easier by the fact that "medical aid in dying" does not include assisted suicide, under the terms of the Quebec Act, and that access to physician-assisted dying in Quebec currently remains restricted to individuals at the end of life. It should be pointed out, however, that in jurisdictions where both options are

possible, there are virtually no physician-assisted suicides and requests for euthanasia are primarily made by end-of-life patients.

## **2.2 Government by the Judges?**

Canadian physicians are certainly not alone in thinking that debate is no longer possible, now that the Supreme Court of Canada has ruled on this matter. However, the Court itself emphasized, twice in fact (once in the *Carter* judgment and again in its response to the government's application for an extension of the suspension of the Court's declaration of invalidity in that ruling), that the best way to address such sensitive issues is through the legislative process. The Court invalidated the *Criminal Code* provisions prohibiting assisted dying, but acknowledged that the federal and provincial parliaments have the power to legislate on the availability of physician-assisted dying under certain conditions.

Indeed, it is important to bear in mind that, in our democratic societies, the heavy burden of making and unmaking laws is not left to the judiciary so much as it is placed in the hands of the officials we have elected to govern us and represent our interests, which would entail a certain minimum amount of public debate, if only in parliamentary settings. In my view, even though it must be respected because it brings us back to the most fundamental rules of law, a Supreme Court decision, albeit unanimous, does not make it possible to skip the complex process of crafting and passing legislation. I am not a legal expert, but I do know that there is growing recognition, in the legal community and elsewhere, of the notion that the validity of a decision rests in large part on the fact that all of the people it concerns have had the opportunity to debate the matter.

In retrospect, it can be said that this is precisely the path that was followed in Quebec on the issue of medical aid in dying, and that the entire exercise was conducted in what many consider an exemplary fashion (since it included extensive public consultation and avoided political squabbling among parliamentarians).

## **2.3 A contentious issue**

The problem, and it is not inconsiderable, is that the consensus ultimately arrived at in Quebec and the Supreme Court decision do not share the same parameters. The challenge now is to come up with legislation, within a very tight time frame, that respects both the Supreme Court decision on physician-assisted dying and the consensus developed on the subject in Quebec, which is already enshrined in that province's *Act Respecting End-of-Life Care*.

As time passes, it would seem that the direction given by the Supreme Court, which borrows directly from foreign legislation, is being viewed as a better source of inspiration than the Quebec Act for the purpose of legislating on medical aid in dying. The Court's position appears to be attracting massive support, perhaps even more than could have been anticipated. The fear that the already thorny issue of physician-assisted dying will become a new bone of contention in

federal-provincial relations is therefore not unfounded. A law modelled on the Supreme Court decision would make Quebec's legislation and the public debate that led up to its passage entirely irrelevant.

Fortunately, I don't believe it is absolutely necessary to choose between a law modelled on the Supreme Court decision and one modelled on Quebec's legislation. Drawing inspiration from Quebec on this issue ultimately would mean, above all else, making sure that the issue is debated as much as necessary, without making too many assumptions on what the outcome might be. Any new legislation adopted without real debate could be as unworkable as the legislation it replaces, due to conscientious objections on the part of physicians, among other reasons.

With a little perspective, it is clear that this entire exercise surrounding physician-assisted dying was made necessary because the absolute prohibition set out in the *Criminal Code* was out of sync with the consensus beliefs of society – so much so that these provisions of the law were no longer enforced. The public was receptive to the idea that such assistance might exist, both in Quebec and in the rest of Canada, if poll results are to be believed. It would be paradoxical to say the least if we wound up with essentially the same problem at the end of this exercise, namely a law that is unenforceable – but this time because it goes much further than the consensus views held by the various players.

But what precisely is the social consensus right now? Is it the same in Quebec as in the rest of Canada? These questions cannot be answered without at least a minimum of public consultation and debate on the essence of the issue, namely: To what extent and in what way do we want to assist those among us who would rather die than endure their suffering?

## **Conclusion**

There has never been and there never will be an easy answer to such a question. But the fact remains that we have just taken a giant step in Canada and Quebec: it is no longer possible to hide behind statements such as “No. Let's not even think about it, because it's against the law!” From now on, we must come up with a different answer both personally and collectively. In my view, this is a positive sign. It seems safe to say that there is now a consensus against total prohibition. As to whether the *Criminal Code* needs to be amended to specify that “physician-assisted dying” is no longer necessarily illegal, that is something for legal experts to determine.

I do believe, however, that we should not be too quick to rejoice and think that we can, by the same token, spell out what will henceforth be considered legal. Once the first step has been taken, there still remains much to do. A whole series of sub-questions arise, each thornier than the last, none of which are addressed in the Supreme Court decision: What about minors? Persons who are unable to give consent? Persons with psychiatric problems? The entire related issue of advance medical directives? Etc. The consensus views on these matters are not quite so clear, and false hopes are assuredly the last thing that people who are suffering need. We must

allow ourselves time to consider and discuss all of these questions, if we want to answer them clearly and honestly. This is the one lesson that can be derived from the Quebec experience.

When you come down to it, this is all we tried to do in Quebec: answer as openly and clearly as possible. From the start, we were profoundly convinced that there had to be an answer other than “no, it’s illegal.” That is why we looked for and eventually found different answers. And it is not because the wall erected by the concept of “no, it’s illegal” has just been officially knocked down that we will necessarily change our minds. I see no need to impose the “Quebec model” on anyone, even temporarily. Conversely, I don’t see how Quebec could be prevented from continuing with its present approach under the pretext of urgency and uniformity.

Having abandoned the notion of complete prohibition, by what legal means can we give time a chance to do its work without too much risk? This too is a matter for the legal experts to resolve. However, I do wish to point out that Quebecers asked themselves the exact same question and answered it by passing the *Act Respecting End-of-Life Care*.