Albertos Polizogopoulos
Direct Line: (613) 241-2701 *Ext:* 243
Email : albertos@vdg.ca

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Christian Medical and Dental Society
Attention: Larry Worthen, Executive Director
9A-1000 Windmill Road
Dartmouth, Nova Scotia B3B 1L7

Dear Mr. Worthen:

Re: Legislative options for Parliament in response to physician-assisted suicide

1. You have asked that I advise of potential legislative options available to Parliament in its legislation in response to the Supreme Court of Canada's decision in *Carter v. Canada*[1] which struck sections 14 and 241(b) of the *Criminal Code*[2] which prohibit assisted-suicide and consenting to death, insofar as those sections applied to physicians and to patients who were of sound mind and who wanted to end their lives.

2. We have discussed five specific means available to Parliament in preparing legislation to regulate the practice of assisted-suicide. In particular, we have discussed and explored legislative options which would serve to protect the conscience rights of healthcare practitioners who may object to assisted-suicide on moral or religious grounds and to protect the religious freedom and religious identity of faith-based healthcare institutions who object to assisted-suicide. Specifically, the means explored are:

    a. Maintaining the *Criminal Code* prohibitions but enacting an exemption for individuals holding a certain license or designation;
    b. Enacting *Criminal Code* prohibitions on coercing individuals to end their lives through assisted-suicide and on coercing individuals to participate in assisted-suicide;
    c. Creating a centralized office which can provide individuals seeking assistance in ending their lives with the information they require to self-refer for assisted-suicide;
    d. Withholding transfer payments to provinces who fail to ensure that healthcare practitioners' conscience rights are protected and that faith-based healthcare institutions' religious freedom and religious identity are protected; and,
    e. Including language which affirms freedom of conscience and religion in any legislation it passes.

3. More specifically, you have asked that I examine whether Parliament has the constitutional authority to enact legislation, which include any of the options listed above, to regulate assisted-suicide.

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1 *Carter v. Canada (Attorney General)*, [2015] 1 SCR 331.
2 *Criminal Code*, R.S.C., 1985, c. C-46 [*Criminal Code*].

Division of Powers

4. As you are aware, the division of powers in the *Constitution Act, 1867*[3] limits healthcare to the jurisdiction of the provincial legislatures. This being the case, if assisted-suicide is framed and characterized as a healthcare issue (which Quebec has attempted to do), then the options available to Parliament are limited and the issue will be pushed down to the provinces and territories.

5. The danger in pushing the issue down to the provinces and territories is threefold. First, there is a risk that certain provinces or territories not enact legislation which would create a legal vacuum. Second, if provinces and territories enact differing legislation, access to assisted-suicide and the manner in which assisted-suicide operates may differ significantly across Canada. Third, the protection of healthcare practitioners' *Canadian Charter of Rights and Freedoms*[4] ("*Charter*") rights to freedom of conscience and religion may not be equally protected throughout Canada.

6. In its recent decision on the Attorney General of Canada's motion to extend the suspension of the striking of the *Criminal Code* provisions, the Supreme Court of Canada provided an exemption from the extension to individuals seeking assistance in ending their lives.[5] Specifically, the Supreme Court of Canada offered an exemption to those seeking assisted-suicide during the extension of the suspension if they obtained approval from a Superior Court of their jurisdiction.[6] The Supreme Court concluded that granting the exemption and requiring judicial approval would address concerns of "fairness and equality across the country".[7] This reasoning appreciates the need for uniform access and regulation across Canada on assisted-suicide.

7. In order to be constitutionally valid, any federal legislation with regard to assisted-suicide must fall within Parliament's jurisdiction to enact as set out at section 91 of the *Constitution Act, 1867*. Sections 91 and 92 of the *Constitution Act, 1867* relegate criminal law to Parliament and healthcare to the provincial legislatures. On its face then, the *Constitution Act, 1867* may appear to suggest that legislating assisted-suicide would be inappropriate for Parliament. This is not so.

8. Parliament may legislate healthcare matters including the eventual act of assisted-suicide. The key in determining whether any legislation oversteps its jurisdiction is to consider the "matter" of the law in question. The "matter" of a law has been described as its "true meaning", "content or subject matter", "leading feature", "true nature and character", "main thrust", or "pith and substance".[8] Where there are potentially numerous subject matters inherent within the statute, the court will decide which is the dominant aspect of

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3 *Constitution Act*, 1867, 30 & 31 Victoria, c. 3 (U.K.).

4 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

5 *Carter v. Canada (Attorney General)*, 2016 SCC 4 [*Carter Motion*].

6 *Carter Motion, supra,* at para. 6.

7 *Carter Motion, supra,* at para. 6.

8 Peter Hogg, *Constitutional Law of Canada, 5th Edition Supplemented* (December 1, 2014) at 15-7 [Hogg].

the statute and characterize that aspect as its "pith and substance". The other features within the statute then become merely incidental or ancillary.[9]

9. The "pith and substance" doctrine enables one level of government to enact laws with substantial impact on matters outside its jurisdiction, provided that the impact on the other level of government's jurisdiction is incidental and not the pith and substance of the law.[10]

10. The issue then is whether Parliament can enact legislation which has no or, at most, incidental impact on matters within the jurisdiction of provincial legislatures. It can.

11. It is important to remember that while the Supreme Court of Canada contemplated that assisted-suicide would be provided by physicians, there is nothing in *Carter* which requires that it be so. In any case, the pith and substance doctrine permits Parliament to enact legislation which has an incidental impact on healthcare provided that the true feature of the legislation is within Parliamentary jurisdiction.

12. Provided that the main thrust and pith and substance of any legislation enacted by Parliament are within the criminal context, it could survive any challenge that the new legislation is outside its jurisdiction. Indeed, Parliament has legislated matters which overlap into provincial or territorial jurisdiction. These include but are not limited to:

    a. *Criminal Code* prohibition on lotteries while making exceptions for those conducted by organizations holding a license issued by the Lieutenant Governor in Council of a province[11] which was upheld by the Supreme Court of Canada as being within Parliamentary jurisdiction.[12]
    b. Federal legislation requiring firearm owners to obtain licenses and to register their firearms[13] which was challenged as being outside of Parliament's jurisdiction in that it sought to regulate property rights. The legislation was upheld by the Supreme Court of Canada as being within Parliament's jurisdiction over criminal law.[14]
    c. Federal legislation regulating assisted human reproduction[15] which was challenged as attempting to regulate healthcare. The Supreme Court of Canada found that some parts of the legislation did overstep Parliament's authority but ultimately, that most of the legislation which prohibited certain practices was criminal in pith and substance and therefore within Parliament's jurisdiction.[16]
    d. Federal legislation legalizing same-sex marriage[17] despite the fact that marriage is within the provincial jurisdiction.[18]

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9 *Halsbury's Laws of Canada – Constitutional Law (Division of Powers)*, at HCL-89 (online).
10 Hogg, *supra*, at 15-9.
11 *Criminal Code*, *supra*, at s. 207.
12 *R. v. Furtney*, [1991] 3 SCR 89.
13 *Firearms Act*, S.C. 1995, c. 39.
14 *Reference re Firearms Act (Can.)*, [2000] 1 SCR 783.
15 *Assisted Human Reproduction Act*, S.C. 2004, c. 2.
16 *Reference re Assisted Human Reproduction Act*, [2010] 3 SCR 457.
17 *Civil Marriage Act*, S.C. 2005, c. 33 [*CMA*].
18 *Constitution Act*, *supra*, at s. 92.12.

13. A further example is with medical marijuana. It remains a crime in Canada to produce, possess, import or traffic marijuana,[19] however, there exists exemptions to these crimes for police officers working who are engaged in under-cover operations[20] or for individuals who produce, sell or use medical marijuana.[21] It remains a crime to produce, possess or sell marijuana unless you fit into one of these exemptions.

14. On the issue of medical marijuana, Parliament maintains a criminal prohibition on producing, selling, possessing and using marijuana while allowing it for medicinal purposes. There is an overlap from criminal law into healthcare. However, the pith and substance of the legislation remains criminal. So long as any legislation enacted by Parliament remains primarily criminal, any overlap into provincial jurisdiction will not be fatal to it.

Legislative Options

Option #1: *Criminal Code* exemption

15. A first option would be to centralize the regulation of assisted-suicide within one office: the Ministry of Justice.

16. If assisted-suicide is legislated in the context of criminal law, it remains within Parliament's jurisdiction and ensures equal access, equal regulation and equal protection throughout Canada. In this regard, Parliament has the option of creating an exemption to sections 14 and 241(b) of the *Criminal Code*, as currently drafted, instead of replacing those sections.

17. Such a regime would be similar to that of the medical marijuana exemption discussed above. Parliament could amend the *Criminal Code* to carve out exceptions to sections 14 and 241(b) for those individuals who hold a special designation or licence which is issued by a federal body. Subsequently, Parliament could regulate (either through legislation or regulations done at the ministerial level) the manner in which that special designation or licence is given, used, maintained and renewed. There is no requirement that the license or designation exempting an individual from sections 14 and 241(b) of the *Criminal Code* only be granted to physicians.

18. Such a regime would allow uniformity across Canada but would also serve to ensure that healthcare practitioners' conscience rights and the religious freedom and religious identity of faith-based healthcare institutions are protected.

Option #2 – Enact *Criminal Code* prohibitions on coercion

19. Parliament may amend the *Criminal Code* to add prohibitions on coercing an individual to end their life through assisted-suicide or to coerce an individual to participate in assisted-suicide.

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19 *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 ["*CDSA*"].
20 *CDSA*, *supra*, at s. 55(2)(b).
21 *CDSA*, *supra*, at s. 56(1).

20. Such prohibitions would be criminal in pith and substance and would fall within Parliament's criminal jurisdiction. Such prohibitions would also serve to protect vulnerable people from being coerced into ending their lives prematurely through assisted-suicide and to protect the *Charter* right to freedom of conscience and religion of individuals including healthcare practitioners and other service providers.

Option #3 – Self referral and a centralized office

21. Parliament could create a federal third-party agency to provide individuals with information related to assisted-suicide including how and where such services can be obtained.

22. Such a regime could be established at the federal level. While healthcare is within the jurisdiction of the provinces and territories, there remains a federal ministry of health which could administer such an office.

23. For example, when there is a federal election, Public Works and Government Services administers a hotline for Elections Canada which people may call for information related to their electoral district. When people call the line, they are given information such as who the candidates are in their riding, where and when they can vote and who the electoral officer in their riding is. This information is available to individuals in the call centre through a government database and is retrieved by using the caller's postal code.

24. A similar centre could be set-up for assisted suicide. Individuals wanting assistance in ending their lives could call a toll free number which would lead them to this call centre. During the call, the caller could be provided with a variety of information including who the providers of assisted suicide are in the caller's region. With that information, the caller could then call the provider themselves and self refer. A similar service could be established online.

25. Arguments in favour of establishing a federal centralized office as opposed to 13 provincial or territorial offices (or no office at all) include economic arguments and arguments regarding access. By having one centralized federal office, people residing in Nova Scotia, British Columbia or Nunavut will all have equal and similar access, information and service.

Option #4 – Withholding transfer payments from provinces

26. Should Parliament choose to push the matter of regulating assisted-suicide down to the provinces and territories, it may still ensure that provinces and territories enact legislation and that the legislation they enact meets certain standards.

27. Should Parliament choose not to directly regulate assisted-suicide, it may and ought to make it a requirement for provinces and territories to do so and to enact legislation which protects vulnerable people from the dangers of assisted-suicide, which protects healthcare practitioners' *Charter* right to freedom of conscience and religion and which protects the freedom of religion and the religious identity of faith-based healthcare institutions.

28. In order to ensure that provinces and territories enact such legislation, Parliament could withhold the Canada Health Transfer from provinces who do not comply.[22]

Option #5 – Language affirming conscience rights.

29. Although marriage falls within the provincial jurisdiction in our division of powers, there is federal legislation governing marriage[23].

30. In 2005, in response to a series of court decisions regarding same-sex marriage, Parliament passed the *Civil Marriage Act* which legalized and regulated same-sex marriage. The *Civil Marriage Act* was created following a Supreme Court reference regarding the legislation. In the reference, the Supreme Court found that denying same-sex couples the ability to marry violated the *Charter.* In response to multiple interveners, the Supreme Court of Canada noted that religious officials ought not be compelled to officiate same-sex marriages if doing so violated their religious beliefs.

31. With the *Civil Marriage Act*, Parliament went further than required by the Supreme Court of Canada and included language favourable to the protection of freedom of religion and freedom of conscience. In the preamble, the *Civil Marriage Act* reads:

> WHEREAS nothing in this Act affects the guarantee of freedom of conscience and religion and, in particular, the freedom of members of religious groups to hold and declare their religious beliefs and the freedom of officials of religious groups to refuse to perform marriages that are not in accordance with their religious beliefs;
>
> WHEREAS it is not against the public interest to hold and publicly express diverse views on marriage;[24]

32. Further, at sections 3 and 3.1, the *Civil Marriage Act*, confirms the above statements. It reads:

> **Religious officials**
>
> **3.** It is recognized that officials of religious groups are free to refuse to perform marriages that are not in accordance with their religious beliefs.
>
> **Freedom of conscience and religion and expression of beliefs**
>
> **3.1** For greater certainty, no person or organization shall be deprived of any benefit, or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise, in respect of marriage between persons of the same sex, of the freedom of conscience and religion guaranteed under the *Canadian Charter of Rights and Freedoms* or the expression of their beliefs in respect of marriage as the union of a man and woman to the exclusion of all others based on that guaranteed freedom.[25]

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22 *Canada Health Act*, R.S.C., 1985, c. C-6 at ss. 7 and 13.
23 *CMA, supra.*
24 *CMA, supra,* at preamble.
25 *CMA, supra,* at ss. 3 and 3.1.

33. Such an approach could be adopted with assisted-suicide. Parliament could include language which confirms that individuals or faith-based healthcare institutions who oppose assisted-suicide are not to be compelled to engage in it and are not to be discriminated against as a result of their opposition. Such language could read as follows:

> **Healthcare practitioners**
>
> **1.** It is recognized that healthcare practitioners are free to refuse to participate in assisted-suicide either directly or indirectly if doing so is not in accordance with their conscience and/or religious beliefs.
>
> **Freedom of conscience and religion**
>
> **1.1** For greater certainty, no person or organization shall be deprived of any benefit, or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise or refusal to exercise, in respect of assisted-suicide, of the freedom of conscience and religion guaranteed under the *Canadian Charter of Rights and Freedoms*.[26]

Conclusion

34. Above are five possible legislative options available to Parliament. These options would permit Parliament to ensure that assisted-suicide is regulated equally across Canada, that access to assisted-suicide is uniform across Canada and that the *Charter* rights of healthcare practitioners and faith-based healthcare institutions are respected across Canada, without sacrificing its constitutional authority or delving into provincial and territorial jurisdiction.

35. The options noted above are not exclusive of each other. They could potentially all exist at once.

36. Parliament could legislate assisted suicide in a manner where providers opt-in by seeking the *Criminal Code* exemption. Parliament could further enact *Criminal Code* prohibitions on coercing individuals to end their lives through assisted-suicide and on coercing individuals to participate in assisted-suicide. Health Canada could establish a central office which provides individuals seeking assistance in dying with the information they require to self-refer and finally, transfer payments can be withheld from provinces and territories who attempt to enact regimes which do not meet Parliament's standards and objectives. Finally, Parliament could include language which affirms conscience rights in any legislation it passes.

37. Should you wish to discuss these recommendations further or alternative options, I would be pleased to do so.

VINCENT DAGENAIS GIBSON LLP/s.r.l.

Albertos Polizogopoulos

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[26] *CMA, supra,* at ss. 3 and 3.1.

Coalition for HealthCARE and Conscience

Recommendations on Conscience

Proposed process –

1. Patient requests information or assistance to end his or her life from his or her physician.
2. Physician discloses her or his conscientious objection to participation in the termination of the life of this patient, including performing assisted death or referring the patient for assisted death.
3. Physician counsels the patient to determine if there is an underlying cause for the request that could be otherwise resolved. This would normally include listening to discern the goals of care of the patient and how these may be met; identifying and offering treatment for any physical, physiological or social issues impacting this request; and providing ongoing treatment, counseling and/or other referral(s) that may be appropriate.
4. If the patient still requests assisted death, the physician provides information to the patient about the medical options available to them. This would include information about all legal medical options.
5. If a patient chooses to be assessed for medical aid in dying, the physician will advise that the patient or their representative can access that assessment directly.

> The federal government could create a mechanism that allows for direct patient access to an assessment for assisted death that is available to the public. This could be accessed by the patient or their representative, on the patient's behalf. In the case of a patient who is in a health care facility and is unable to make the contact on their own, the patient may request a transfer of care to another physician, which would be facilitated by the facility. The physician with the conscientious objection must not be obligated to find a physician for the patient as this will be considered facilitating and actually participating in assisted death. Facilities that do not allow assisted death on their premises may transfer patients who have chosen assisted death to other facilities.

6. Upon request of the patient, the physician makes available the patients' chart to the physician conducting the assessment.
7. The physician may maintain a therapeutic relationship with the patient for care unrelated to the assisted death unless the patient requests a transfer of care to a specific physician selected by the patient.
8. The physician will not obstruct the patient from accessing legal alternatives at end of life.
9. The death certificate and any documentation or reporting of assisted death is the responsibility of physician who performs assisted death.
10. Physicians should not have to refer a patient for assisted death either directly

or to a third party. Note: a proposal similar to this one has been approved by the Canadian Medical Association.

Why Conscience Protection is so important

Doctors can object to participating in physician-assisted death for a variety of reasons. When patients ask to die it is a cry for help and an indication that there is an underlying physical or psychological problem that needs to be resolved. This is especially true for patients who experience mental health difficulties. Often doctors find that with the proper treatment and support, patients who were once convinced that they needed to die can go on to live life comfortably once the underlying concern is resolved. Since all of us at one point or another will be patients ourselves we need to be concerned that physicians will consider the underlying issues in an assessment for assisted death.

Many doctors may have moral convictions on this issue that come from their professional judgment, the Hippocratic oath, their religion or creed. These convictions may apply to assisted death in general or to the circumstances of particular patients. For instance, a patient who has requested assisted death may have refused potentially life saving treatments against their doctor's advice, or they may be motivated by financial pressures, or they may wish to end their lives without informing their loved ones. Even doctors who are theoretically in favour of assisted death may have qualms about facilitating the procedure under these kinds of circumstances, even when the patient satisfies the legal criteria.

For Christian doctors in particular, the stakes are very high – moral theologians have indicated that a referral for assisted death is formal cooperation in the death of the patient and the moral equivalent of performing the act itself. This is breaking one of God's Ten Commandments. Physicians in this category are part of a religious minority who rely on the Charter of Rights and Freedoms as protection against laws that would force them to recommend something they cannot.

Referral means recommending a particular course of medical treatment, or sending a patient to an expert to recommend a particular treatment. Referral of any kind is a form of participation, making our members accomplices to the controversial procedure. In criminal law, an accomplice is as guilty as the person who commits the crime.

Physicians are professionals and must retain the ability to freely act in their patient's best interests. The best way to protect the public, the patient and the role of the physician is to safeguard physicians' conscience rights so they can exercise their professional judgment with moral integrity and independence.

The physician-patient relationship must be based on openness, honesty and trust. Physicians can discuss options with patients, allowing the patient to make a

fully informed, autonomous decision, even when the physician disagrees with the decision. We are not trying to impose our values on the patient – but we must maintain our right to step back from the process when our moral convictions will not allow us to participate in something that we are convinced is not in the patient's long-term interests.

When the Supreme Court of Canada struck down the criminal prohibition against physician assisted death (PAD) the court held that a physician's decision to participate in these procedures was a matter of conscience, protected by the Canadian Charter of Rights and Freedoms. Doctors cannot be forced to participate in assisted suicide or euthanasia against their will (Carter, para. 132). Participation includes referral. No foreign country or jurisdiction that has legislated euthanasia, has forced physicians to refer for euthanasia.

Recent Canada-wide public opinion polls indicate that the majority of respondents do not consider it appropriate to force a physician to refer for a procedure against their moral convictions, even though the patient might request the procedure.

The Hippocratic Oath informed our approach to medicine for 2400 years. It is unthinkable that physicians should be disqualified from practice simply because they wish to follow the Oath in the practice of medicine.

Further information: Please contact Larry Worthen, Executive Director, CMDS Canada (902) 880-2495 lworthen@cmdscanada.org

[i] In a May 2015 survey of 1,201 Canadians conducted by Abingdon Research (overall margin of error +/- 2.8%, 19 times out of 20), the majority of respondents did not support requiring doctors to refer for procedures that were against their moral convictions. The questions asked along with the results are reproduced below.

- Imagine a doctor disagrees with a patient about a treatment the patient wants, because of the doctor's moral convictions. The doctor cannot be forced to administer the treatment and the patient cannot be forced to follow the doctor's orders. What should be the outcome?

• The doctor should not be required to provide a referral to another doctor who will administer the treatment (12%)
• The doctor should tell the patient how to access the procedure, but not provide a formal referral (44%)
• The doctor should be required to provide a referral to another doctor who will administer the treatment (44%)

Note that 56% of respondents said that the physician should not have to refer, made up of those who would require information only (44%) and those who required no action at all. (12%) Furthermore, the majority of respondents supported direct access as a valid option when asked the following question:

- In some circumstances, patients can self-refer to a physician or service for a procedure. In a situation where a physician's moral or religious convictions do not allow them to refer for a procedure that is requested by a patient, and the patient can self-refer themselves for the service, what should happen?

• The physician must refer for the procedure (31%)
• The physician should have to make the patient aware that they can refer themselves for the procedure, but make no referral (54%)
• The physician should not have to make the formal referral (16%)

- When asked specifically about physicians whose religious beliefs would forbid them from referring to another physician who would provide euthanasia, 58% of respondents felt that those physicians should not have to perform euthanasia or refer for it. In contrast, 28% of respondents would require a referral, while 14% would require a physician to perform euthanasia, at least under some circumstances. The margin of error is higher on this question: +/- 5%, 19 times out of 20.