Justice Centre
for Constitutional Freedoms

Bill C-7: The Danger of Undue Influence:

The Right to Life of the Elderly and Infirm, and Physician's Conscience Rights

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Bill C-7: The Danger of Undue Influence

Undue influence of the vulnerable, isolation and abuse as a result of COVID lockdowns

The introduction of *Bill C-7: An Act to amend the Criminal Code (medical assistance in dying)* is being heralded by the federal government and some patient advocacy groups as a necessary step to protect patients who have lost capacity but who at one point confirmed a desire to commit suicide with the assistance of their physician through what has become known as medical assistance in dying ("MAiD"). Bill C-7:

> …permit[s] medical assistance in dying to be provided to a person who has been found eligible to receive it, whose natural death is reasonably foreseeable and who has lost the capacity to consent before medical assistance in dying is provided, on the basis of a prior agreement they entered into with the medical practitioner or nurse practitioner.[1]

If Bill C-7 becomes law, however, a patient could be killed by her physician even though the patient has lost the ability to instruct her physician at the material time and may have changed her mind. Approximately 7% of patients who formally instruct their physicians of their desire for MAiD later change their minds.[2] This statistic strongly suggests that Bill C-7, if passed in its current form, would consistently result in the deaths of some incapacitated patients who no longer want to commit suicide. In essence, such individuals will be executed by the state against their will, powerless to object.[3]

In addition, Bill C-7 removes the prior safeguard in the *Criminal Code* that *two* independent witnesses evidence the *independent* instruction of the patient. This safeguard is a check against coercion and undue influence. Bill C-7 concerningly reduces the number of independent witnesses to one.

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[1] Summary, Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)

[2] *Commission Sur les soins de fins de vis*, April and October, 2019, pages 61 and 25, respectively. This number is not statistically insignificant; it represents nearly 400 people over the course of 5 years who changed their minds to live.

[3] Aside from being morally repugnant and reprehensible, such a scenario would also be a profound and permanent violation of section 7 of the *Charter* and the protection of the right to life, and therefore unconstitutional.

Many patients today are already at a heightened risk for undue influence and coercion due to the COVID lockdowns. Canadians generally are dealing with unprecedented levels of stress, isolation, loneliness and suicidality as a result of the COVID lockdowns.[4] These symptoms are far more pronounced in long-term care homes where residents have been isolated for months without visitors, and in some cases in appalling conditions which include bullying from staff, cockroach infestations and rotten food.[5] Depression, despair, and a lack of will to live are often born out of abuse, neglect and isolation. Such circumstances conceivably pave the way for undue influence and coercion for improper purposes, such as a beneficiary coercing a testator to request MAiD in order for the former to obtain a material gain and the latter to escape isolation and abuse. The reduction of the number of witnesses to one therefore increases the spectre of undue influence.

Moreover, the suffering of patients who are isolated from loved ones by public health edicts under the justification of "COVID prevention" has been well-documented[6] and is currently the subject of a *Charter* challenge in Ontario.[7] The suffering of the elderly and other residents in long-term care homes who are prevented from leaving the facility, are deprived of their families, and prevented from socializing with other residents, and enjoying the outdoors, cannot be exaggerated. Long-term care homes during COVID lockdown measures have blurred the lines between care and incarceration.

Finally, Bill C-7 removes the ten-day waiting period to receive MAiD. If passed, a patient could request and receive MAiD on the same day. The existing ten-day period is necessary for personal reflection, but also to assist in ascertaining the underlying reasons for the request for MAiD, and to attempt to determine the question of undue influence or abuse.

Bill C-7 would authorize people who are not terminally ill, for example those suffering disproportionately from the lockdowns and state-compelled isolation and abuse and neglect in

[4] https://www.piquenewsmagazine.com/bc-news/covid-19-pandemic-mental-health-crisis-calls-up-suicides-down-2871540;
[5] https://www.cbc.ca/news/canada/toronto/military-long-term-care-home-report-covid-ontario-1.5585844; https://www.cbc.ca/news/politics/long-term-care-pandemic-covid-coronavirus-trudeau-1.5584960
[6] *Ibid*, also see https://www.theglobeandmail.com/canada/article-new-data-show-canada-ranks-among-worlds-worst-for-ltc-deaths/
[7] https://torontosun.com/news/local-news/levy-the-pandemic-jail-gates-closing-yet-again; the Justice Centre represents family members who are suing the Ontario government for the forced isolation of seniors away from their family members.

long-term care homes, to enlist the assistance of physicians in order to commit suicide. Parliament must be mindful that the lockdowns are creating an epidemic of loneliness in seniors and residents of long-term care homes, and it ought to be very wary of creating a "solution" in the form of relaxed safeguards for physician-assisted suicide.

Conscience and Religious Rights of Medical Practitioners

Many physicians object to administering MAiD on ground of religion and conscience, and object to referring for MAiD out of a sense of moral culpability for the death of a patient. Far from making MAiD less objectionable to such individuals, the increase of the likelihood of contributing to a wrongful death and the removal of protective safeguards are growing concerns which further implicate the fundamental conscience and religious freedoms as protected by section 2(a) of the *Canadian Charter of Rights and Freedoms*. Bill C-7 even conceivably opens the door to a re-litigation of the issues in *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393.[8]

Parliament must recognize that, while there is a right to die under the requirements set forth in *Carter* and pursuant to the provisions of the *Criminal Code*, those who avail themselves of MAiD will be gone, while those who are tasked with implementing it will remain. The removal of checks and balances regarding MAiD will complicate and create irreconcilable crisis for some medical practitioners.

It is in the best interests of all Canadians that those practitioners who care for patients on a daily basis be able to perform their duties with a clear conscience, and with the knowledge that they have been true to both themselves and their perception of their medical and ethical mandate.[9]

The balance between patient and doctor's rights

In *Carter*, the Supreme Court of Canada discussed and reiterated the conscience and religious rights of medical practitioners, stating that, "nothing in the declaration of invalidity which we

[8] This case involved the mandatory effective referral requirement in Ontario. If the MAiD regime materially changes it may well change the justification analysis under section 1 of the *Charter*.
[9] See for example the traditional Hippocratic Oath: http://classics.mit.edu/Hippocrates/hippooath.html

propose to issue would compel physicians to provide assistance in dying."[10] The Court stated that it did "not wish to pre-empt the legislative and regulatory response to [*Carter*]." Instead, the Court "underline[d] that the *Charter* rights of patients and physicians will need to be reconciled." Thus, it is apparent that the Court intended Parliament's legislative response to address the issue of medical practitioners' conscience rights. Bill C-7 tips the scale further against doctors who have deep-seated moral and religious concerns regarding their involvement in causing the intentional deaths of their patients by helping them to commit suicide.

The moral practice of medicine

Medicine must always be seen to be on the side of life, as is affirmed by the Hippocratic Oath's 'do no harm' directive.

Similar to the Hippocratic Oath, the Canadian Medical Association Code of Ethics also promotes the ethical practice of medicine, exhorting physicians to "[r]esist any influence or interference that could undermine your professional integrity", "[r]efuse to participate in or support practices that violate basic human rights" and "[r]ecommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others."[11] [Emphasis added]

The Physician's Oath in the Declaration of Geneva[12] provides further examples of the importance of morality and ethics to the practice of medicine:

> I solemnly pledge to consecrate my life to the service of humanity;
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> 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;

[10] *Carter* at para. 132
[11] Available at http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PDO Co4-06.pdf.
[12] Available at http://www.wma.net/en/30publications/l0policies/gl/.

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**[13] 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.

Courts, physicians and the Canadian Medical Association recognize that you cannot remove morality from medicine. For example, the Ontario Court of Appeal in *Flora v. Ontario Health Insurance Plan*, 2008 ONCA 538 ("Flora") relied upon the testimony of Dr. Peter Singer, an Ontario professor of medicine, a bio-ethicist and the Director of the University of Toronto Joint Centre for Bioethics. Dr. Singer had testified at trial that "the appropriateness of a proposed medical treatment for a particular patient is 'not purely a medical concept'. To the contrary, 'a physician's determination about whether treatment is appropriate includes not only medical facts like the projected chance of success but also ethical considerations."[14] The Court also noted that "[i]n their evidence before the Board, Mr. Flora's U.K. doctors and Dr. Wall also confirmed that ethical considerations form an essential part of medical decision-making concerning patient selection for a LRLT [a living-related liver transplantation]."[15] In the case before it, the Court

[13] Statement at page I
[14] Flora, at para. 75
[15] Flora, at para. 75

found, that "the thesis that the appropriateness of a LRLT turns solely on its medical efficacy brushes aside the centrality of ethical considerations in transplant decision-making."[16]

Compelling doctors to assist their patients in committing suicide, or refer for such assistance in the circumstances set out by Bill C-7 is deeply concerning, especially in the context of the COVID lockdowns and the isolation of society's most vulnerable. In some respects, the timing of Bill C-7 could not be worse.

Euthanasia for dementia patients

Bill C-7 authorizes the euthanasia of dementia patients through the use of advance directives. However, euthanizing patients with dementia is morally problematic and highly controversial. The state ought to pay far greater attention to constitutional considerations, especially the right to life. At bare minimum, physicians must carefully consider the influence and psychological situation of their caregivers, the susceptibility of patients to depression and demoralization, the patients' ability to understand and to process information, as well as their emotional state.

The Belgian Federal Control and Evaluation Commission had on various occasions endorsed euthanasia for patients who suffered from depression and dementia.[17] Euthanizing a patient at an early stage is seen in the Netherlands as problematic, however, because the patient is euthanized prematurely, depriving them of months or years of life. Euthanizing in the later stages of dementia will mean euthanizing patients who do not know what is happening to them. Terminating the life of a patient who is not aware of what is happening to her is problematic in the eyes of Dutch experts who condone euthanasia for patients with dementia in particular circumstances:[18] As noted by philosopher Raphael Cohen-Almagor, a proponent of MAiD but an opponent of euthanasia, "thus performing euthanasia prematurely is a shame because it cuts life in earnest, and performing it at a later stage upon advance directives might not be relevant to the present condition, and indeed might negate the patient's present wishes. Either way, euthanasia of patients with dementia is thus morally wrong."[19]

[16] Flora, at para. 76
[17] https://www.bmj.com/content/360/bmj.k593/rr-68
[18] file:///C:/Users/ochuk/Downloads/FirstDoNoHarm-EuthanasiaofPatientswithDementiainBelgium.pdf
[19] file:///C:/Users/ochuk/Downloads/FirstDoNoHarm-EuthanasiaofPatientswithDementiainBelgium.pdf

Cohen-Almagor also notes: :

> People remain beings of the human species notwithstanding their physical or mental condition. They still deserve to be treated compassionately, professionally, and morally. They should not be treated as we treat an asparagus or kohlrabi. Vegetables are means to an end. We use them for survival and pleasure. Humans are never a means to an end. Humans are always worthy of respect and concern. Furthermore, reducing the notion of personhood to the ability to reason does not do it justice. Humans are complex beings with many abilities: cognitive, mental, spiritual, emotional, and physical. We derive happiness and a sense of satisfaction from many things that are not necessarily related to our ability to reason. People can realize themselves, be autonomous, and behave irrationally. People may choose to act on emotions rather than logic and reason (Cohen-Almagor, 1994, 9–19). People may derive an immense sense of happiness and satisfaction from utter nonsense. Contrary to Dworkin's arguments, my contention is that even the thin pleasure of peanut butter and jelly is worthwhile. Past autonomous decisions should not categorically and unequivocally trump present nonautonomous life. People may find pleasure in things that had no importance for them in the past. Their present order of priorities should not be ignored.[20]

Many doctors continue to have a moral and ethical problem with removing their patients as a means of "treating" them, and these concerns must not be ignored by Parliament. As noted by Dr. Ole J Hartling, former chairman of the Danish Ethical Council, in the *BMJ*,

> Reference to suffering holds an altogether obvious appeal for everyone including anyone who has taken the Hippocratic Oath. However, physician-assisted suicide or euthanasia is not about alleviating or removing a person's suffering but about removing the one who is suffering. It is worthwhile thinking about what this means to the patient-doctor relationship.[21]

The *Charter* protects freedom of conscience and religion for physicians

The foundational principles concerning freedom of religion were laid down by the Supreme Court of Canada in *R. v. Big M Drug Mart Ltd.*:[22]

> 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 hindrance or reprisal, and the

[20] file:///C:/Users/ochuk/Downloads/FirstDoNoHarm-EuthanasiaofPatientswithDementiainBelgium.pdf
[21] *Supra,* footnote 17.
[22] *R. v. Big M Drug Mart Ltd.*, (1985] I SCR 295 at 336-37 [*Big M Drug Mart*]

> 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 ...
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> W*hat 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."*

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.

The Supreme Court of Canada in *Carter*, in finding that the government prohibition on assisted suicide violated patients' *Charter* section 7 rights to life and security of the person in certain circumstances, specifically warned about compelling physicians to participate in assisted suicide:

> In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note - as did Beetz J. in addressing the topic of physician participation in abortion in *R. v. Morgentaler* - that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96).[23]

[23] *Carter* at para. 132

Recommendations:

1. The number of witnesses required to attest to the independence of an election for MAiD should remain at 2 persons;

2. The ten-day waiting requirement to receive MAiD ought to remain undisturbed.

3. The requirement that capacity and current instruction to receive MAiD ought to remain undisturbed.

4. If Bill C-7 is passed in its current form, a protection for medical practitioners ought to be added to clearly stipulate that no physician will be required to participate or refer for MAiD.

About the author

Jay Cameron was called to the Alberta Bar in 2008. He has testified previously at Parliamentary sub-committees on MAiD. He has appeared at every level of court in Alberta and other provinces, as well as at the Supreme Court of Canada, and is the Litigation Manager at the Justice Centre for Constitutional Freedoms (jccf.ca). The Justice Centre is a public interest law firm and registered charity that defends the *Charter* rights and freedoms of Canadians. The Justice Centre relies entirely on voluntary donations from Canadians to carry out its work in defence of "the free and democratic society" as envisioned by the *Charter*.