BRIEF BY MR. JEAN-PIERRE MÉNARD, Ad. E.

BILL C-14 – An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)

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ABRIDGED CV OF

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RELEVANT TO END-OF-LIFE CARE

Mr. Jean-Pierre Ménard has been a member of the Quebec Bar since 1980. He practises with the law firm of Ménard, Martin, where he specializes in health law and defending patients' rights, particularly in terms of medical liability and legal psychiatry. Mr. Ménard teaches Medical Liability and Legal Psychiatry in the Master's of Health Law program at the University of Sherbrooke, as well as Health Law and Policy in the Master's of Health Administration program in the University of Montréal's Faculty of Medicine.

Since the beginning of the debate on medical assistance in dying in 2009, Mr. Jean-Pierre Ménard has been closely involved with the Quebec Bar in framing the legal discussions on this subject. Furthermore, as chair of the expert legal panel created by the Government of Quebec to study implementation of the recommendations of the National Assembly's Select Committee on Dying with Dignity, he prepared a voluminous report that led to the drafting of the *Act respecting end-of-life care.*[1] He was then an active participant in the legislative process to adopt the bill. His personal contribution was highlighted by the Premier when the bill was adopted.

Mr. Ménard also became involved in the implementation of the Act as representative of the Quebec Bar on various committees. He continues to give lectures and provide training on the Act for all the sectors concerned. Today, he still plays an active role with the Quebec Bar in implementing the Act.

[1] LQ, 2014, c.1.

This analysis of Bill C-14 is based on a different legal framework than that of the other Canadian provinces. To date, Quebec is the only province with legislation that completely regulates medical assistance in dying. The *Act respecting end-of-life care* (RLRQ c. 32-001) has been in force in Quebec since 10 December 2015. To date, there have been several dozen cases of medical assistance in dying. We are therefore in a position to share with you the Quebec experience from the legal standpoint.

This brief will also present the following elements as they relate to Bill C-14:

a) Aiding suicide;
b) The eligibility criteria for medical assistance in dying;
c) The safeguards;
d) The declaration;
e) Monitoring;
f) The conscience clause.

a) <u>Aiding suicide</u>

Bill C-14 introduces aiding suicide as the process for practising medical assistance in dying.

The bill describes it as follows:

> (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Quebec's legislation does not cover this practice. In fact, medical assistance in dying was not legal when that Act was adopted, which was prior to the Supreme Court judgment. Including assisted suicide among its provisions would have constituted an infringement on federal jurisdiction in criminal law, and the legislation would therefore have been vulnerable to a constitutional attack based on the division of powers. Quebec's Act is health legislation that covers various aspects of end-of-life care besides medical assistance in dying.

In my opinion, practising medical assistance in dying by aiding suicide raises a number of difficulties. The first involves the safeguards.

Paragraph (h) of section 241 in particular is problematic.

This paragraph requires the medical practitioner or nurse practitioner, immediately before providing medical assistance in dying, to give the person an opportunity to withdraw their request and to ensure that the person gives express consent to receive medical assistance in dying.

However, the medical practitioner is not present when medical assistance in dying is provided by aiding suicide. In fact, there are no professionals present to ensure respect for this formality. The bill does not provide for any obligation of any kind on the individuals who are actually present when the person commits suicide. Parliament may decide either to ensure that the conditions provided for in paragraph (h) will not be applicable to aiding suicide, or to require that any professional present verifies that this condition has been met, because the medical practitioner is not there with the patient.

Aiding suicide poses other difficulties. From the standpoint of medical ethics, some physicians who are open to providing medical assistance in dying when they administer it themselves may hesitate or even refuse to do so by aiding suicide. In simply providing the substance and letting patients themselves manage their end of life, physicians may be contravening their ethical obligations to provide continuity of care and not abandon patients. Furthermore, it is impossible to verify the conditions under which the person will take the substance, or whether they will do so correctly or in a way that limits their suffering.

There is also the difficulty of the declaration required by the legislation and the monitoring of the practice. Those issues will be discussed later in this document.

b) The eligibility criteria for medical assistance in dying

In *Carter*, the Supreme Court of Canada recognized a constitutional right for all Canadians, based on section 7 of the *Canadian Charter of Rights and Freedoms,* to receive medical assistance in dying when they meet the conditions established by the Court. These conditions are repeated almost word for word in the clause of the bill amending s. 241(1).

Thus,

a) the person must have a serious and incurable illness, disease or disability;

b) their capabilities must also be in an advanced state of irreversible decline;

c) furthermore, their situation must be causing them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under acceptable conditions;

d) finally, their natural death must have become reasonably foreseeable, even if there is no prognosis as to the specific length of time they have remaining. Death must be foreseeable within a timeframe that is not specified in the legislation.

In defining what constitutes a grievous and irremediable medical condition, the bill reduces and limits the scope of the criterion set by the Supreme Court of Canada in *Carter.* Section 7 of the Charter*,* as interpreted by the Supreme Court, gives broader scope to the right to personal liberty than the provisions of the bill. Such an important restriction could open the door to a new legal challenge to the legislation, on the

grounds that it does not go as far as permitted by the Charter. The Supreme Court ruling in *Carter* involved a patient named Kathleen Carter, whose death was not reasonably foreseeable, but who was suffering from a serious and incurable disease. It was for her and other people in similar situations that the Supreme Court recognized the right to request medical assistance in dying. The bill as drafted removes their constitutional right recognized by the Supreme Court to request and receive medical assistance in dying.

The bill's definition of a grievous and irremediable medical condition essentially repeats the conditions established in Quebec's legislation, which is more restrictive than what is now permitted by the Charter as a result of the judgment in *Carter.*

The person must therefore have a serious and incurable illness, disease or disability. The term "incurable" is included among the criteria in Quebec, but is not found in the *Carter* judgment. The notion of "irremediable" illness also resembles the criterion established in Quebec's legislation.

The person must be in an advanced state of irreversible decline in capabilities. That is one of the criteria in Quebec's legislation, but not in *Carter.*

The criterion of suffering is the same as in Quebec's bill and Act. Finally, the bill introduces a condition that differs significantly from the criteria set out in *Carter,* by requiring that natural death has become reasonably foreseeable, taking into account all

of the person’s medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. Quebec’s legislation requires that the person be at the end of their life.

Therefore, according to the definition proposed in the bill, a person who becomes a quadriplegic following an accident would not be considered eligible because their death has not become reasonably foreseeable. On the other hand, a person suffering from multiple sclerosis and who is at an advanced stage of the disease could be considered eligible, according to the bill, because their natural death has become foreseeable.

The criterion found in the federal bill is broader than that in Quebec’s legislation. While the latter does not require that the patient be dying or terminal, their end of life must be foreseeable in the short term and exist in the context of an advanced state of decline in capability and of suffering. The timeframe is longer than a few days, or even a few weeks, but should not exceed six months in order to respect the spirit of Quebec’s legislation.

The criterion of foreseeable death in the federal bill is vaguer, unless it is interpreted equally with the other criteria provided, including the advanced state of decline of faculties, which brings it closer in line with Quebec’s legislation. In our view, this criterion, which is open to arbitrary interpretation, could render the person’s

fundamental constitutional right to medical assistance in dying expandable or reducible, depending on the physician's interpretation.

For that reason, I believe that for the bill to comply with the *Charter,* the amendments to section 241.2(2) must be withdrawn.

c) <u>The safeguards</u>

Generally speaking, I find the safeguards set out in the bill's amendment to subsection (3) of section 241.2 to be adequate and more or less in line with those established in Quebec's legislation. However, subsection (5) regarding the independence of the witness to the patient's signature on the request for medical assistance in dying seems unnecessarily stringent.

The witness is only attesting to the patient's signature. It is up to the medical practitioner to ensure that the patient is able to consent and that the patient's consent is completely free of any influence or external pressure. The proposed rules would be relevant only if they were referring to a person required to consent to an end-of-life decision on behalf of the patient. We suggest limiting the restriction as to choice of witness to the members of the medical team who will be administering the medical assistance in dying. It will often be family members who act as witnesses to the signature.

d) The declaration

The bill proposes a system whereby the medical practitioner or nurse practitioner who receives a request for medical assistance in dying must provide the information set out in the regulations to a person designated by the Minister of Health or another person designated by the regulations. Among other things, this provision is intended to enable the Minister of Health to monitor medical assistance in dying in Canada.

In the case of aiding suicide, the medical practitioner or nurse practitioner would only be able to attest to the fact that a request was received. They could not certify that the patient had actually taken the substance, or when.

In order to avoid a multiplication of formalities and reports, the bill should allow the Minister to exempt health professionals, in provinces where monitoring mechanisms deemed satisfactory by the federal government exist, from the obligation of providing information on medical assistance in dying.

Nothing would prevent the federal authority from requiring a province that has such a monitoring mechanism to provide certain data related to medical assistance in dying for the purposes of monitoring at the national level.

e) Monitoring

Another problem between Quebec's legislation and the federal bill involves the issue of monitoring medical assistance in dying. Quebec already has a stringent control mechanism in its legislation that requires the physician to inform the Council of Physicians, Dentists and Pharmacists, or the Collège des Médecins, depending on the circumstances, as well as the Commission on end-of-life care, that medical aid in dying has been provided.

Preference should be given to mechanisms that enable the federal and provincial governments to work in harmony in order to avoid the application of different monitoring requirements and standards. Because medical assistance in dying falls under shared constitutional jurisdiction, it will be important to distinguish between monitoring measures that can be applied by a province, and those that can be applied by the federal government. Each level of government should be able to monitor application of the law within its respective area of jurisdiction. It is not appropriate to have the federal government monitor all aspects when there is a law allowing the province to monitor the practice of medical assistance in dying.

f) The conscience clause

Bill C-14 does not include a conscience clause to protect the right of a medical practitioner or other professional to refuse to practise medical assistance in dying.

I firmly believe that the bill should not include such a clause. Bill C-14 is a bill amending the *Criminal Code.* It deals with criminal law.

Conscience clauses more properly fall under medical ethics. The code of ethics of each provincial college of physicians establishes such clauses. In the case of Quebec, article 24 of the *Code of ethics of physicians* provides that:

> **24.** A physician must, where his personal convictions prevent him from prescribing or providing professional services that may be appropriate, acquaint his patient with such convictions; he must also advise him of the possible consequences of not receiving such professional services.

The physician must then offer to help the patient find another physician.

The Quebec *Act respecting end-of-life care* also contains two relevant provisions:

> 50. A physician may refuse to administer medical aid in dying because of personal convictions, and a health professional may refuse to take part in administering it for the same reasons.
>
> In such a case, the physician or health professional must nevertheless ensure that continuity of care is provided to the patient, in accordance with their code of ethics and the patient's wishes.
>
> In addition, the physician must comply with the procedure established in section 31.
>
> 31. A physician practising in a centre operated by an institution who refuses a request for medical aid in dying for a reason not based on section 29 must, as soon as possible, notify the executive director of the institution or any other person designated by the executive director and forward the request form given to the physician, if that is the case, to the executive director or designated person. The executive director of the institution or designated person must then take the necessary steps to find, as soon as possible,

> another physician willing to deal with the request in accordance with section 29.
>
> If the physician who receives the request practises in a private health facility and does not provide medical aid in dying, the physician must, as soon as possible, notify the executive director of the local authority referred to in section 99.4 of the Act respecting health services and social services (chapter S-4.2) that serves the territory in which the patient making the request resides, or notify the person designated by the executive director. The physician forwards the request form received, if that is the case, to the executive director or designated person and the steps mentioned in the first paragraph must be taken.
>
> If no local authority serves the territory in which the patient resides, the notice referred to in the second paragraph is forwarded to the executive director of the institution operating a local community service centre in the territory or the person designated by the executive director.

As such, it would be completely unnecessary to add an additional provision to the *Criminal Code,* and doing so could lead to standards that differ from those established by the Collège des médecins or provincial legislation.

The provisions providing physicians with a conscience clause, and those guaranteeing that they will not be prosecuted for practising medical assistance in dying in compliance with Quebec's Act, provide them with sufficient protection.

<u>Conclusion</u>

Medical assistance in dying is of particular interest to all Canadians. There is broad consensus that access to medical assistance in dying should be permitted, within strictly defined limits. The debate is not about whether medical assistance in dying should be

permitted, but rather how to regulate this practice so that it affirms individual autonomy while protecting those who are vulnerable.