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A commentary *on Carter v Canada* and medical aid in dying

1. Introduction & Context of *Carter*[1]

In 1993, a woman named Sue Rodriguez made a claim before the Supreme Court of Canada in order to be allowed, legally, to seek physician assistance in dying. She was suffering from ALS, or amyotrophic lateral sclerosis. ALS is a disease that affects nerve cells in the spinal cord, which causes muscles to atrophy and harden, one by one, causing vital organs to fail, eventually causing death.[2]

Mrs. Rodriguez' prognosis was between two and fourteen months. Although she could function in the short term, she knew her situation would deteriorate rapidly and she would not be able to survive without life support and enduring tremendous suffering. She feared that her fate, if left to pass away naturally, would be to die due to choking, inability to breathe on her own or pneumonia.[3] Notably, although a person with ALS loses control over their body, they are fully and tragically mentally competent and aware of their physical condition. Mrs. Rodriguez therefore asked the Courts to allow her to seek a physician's assistance in ending her life at the time of her choosing. She did not want to end her life prematurely by committing suicide, yet she also did not want to experience the slow and painful death which ALS would inevitably impose.

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1 *Carter v Canada (Attorney General)*, [2015] 1 SCR 331, para 1.

2 For more information on ALS, see the ALS Association website, http://www.alsa.org/about-als/what-is-als.html, 10.12.2017.

3 See *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519, p. 588.

The Supreme Court has long recognized the notions of human dignity, personal autonomy and the ability to control one's physical and psychological integrity free of state interference as values falling under the scope of s. 7 of the *Canadian Charter of Rights and Freedoms*.[4] However, in 1993, Canadian society had not seemed to come to a consensus regarding the decriminalization of physician-assisted suicide let alone the constitutionality of an active or passive regime.[5] It was therefore not surprising that the Supreme Court delivered a divided decision in *Rodriguez*, with five out of nine judges opting for a more cautious approach, prioritising human life and protection of the vulnerable. The majority held that, although s. 7 was impugned by s. 241(*b*) of the *Criminal Code*,[6] the principles of fundamental justice justified the denial of Canadians' rights to control the time and circumstances of their own death. The majority's concern was in the lack of appropriate safeguards and the high risks of abuse, which underpinned the reasoning that the blanket prohibition was not arbitrary or unfair as its principal interest was protection of the vulnerable.[7] The majority also assumed, without deciding on the subject, that if the blanket prohibition infringed s. 15 of the *Charter,* it would be justified under s. 1.

Alternatively, two of the four dissenting judges (McLachlin and L'Heureux-Dubé) based their opinions on a s. 7 infringement, stating it was not justified by s. 1. They refused to apply s. 15 in the case because they found it did not involve discrimination following the true focus of s. 15.[8] Lamer C.J. held that the law violated s. 15 only, and Cory J found

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[4] *Canadian Charter of Rights and Freedoms*, s. 7, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 ("*Charter*"). Per La Forest, Sopinka, Gonthier, Iacobucci and Major, writing for the majority in *Rodriguez v. British Columbia (Attorney General), Ibid,* p. 521 and 588. Also see *Conway v. Fleming*, [1999] OJ No 880 (QL); *Wakeford v. Canada*, 1998 CanLII 14931 (ON SC), para 26; *R. c. Turmel*, 2001 CanLII 40032 (QC CS), para 127.

[5] Of note, the decriminalization of assisted suicide had not occurred internationally at the time of *Rodriguez*, albeit several proposals for reform that were brought forward in Washington and California, to name a few. *Supra* note 3, p. 582.

[6] Which prohibits anyone from aiding or abetting a person to commit suicide.

[7] *Supra* note 3, p. 522.

[8] *Ibid*, p. 524. Also see *Carter v Canada (Attorney General)*, [2012] BCSC 886, at para 889.

that it violated both s. 7 and s. 15 for the same reasons expressed by his dissenting colleagues.[9]

Cory J compared a capable patient's legal ability to refuse treatment,[10] with an incapable and terminally ill patient who decides to terminate life preserving treatment and whose decision is executed by another person as per the patient's instructions. He saw no difference between the two, thus found no reason to deprive the latter of the legal ability to choose to end their lives via an intermediary. "Since the right to choose death is open to patients who are not physically handicapped, there is no reason for denying that choice to those that are."[11]

Despite the division in *Rodriguez*, legal recognition of physician-assisted dying would not be on the horizon until two decades later, when the highest court in Canada was presented once again with the question of whether the blanket prohibition provided by s. 241(*b*) was unconstitutional – but in a different Canadian context compared to that of 1993.

Indeed, the political and legal landscape had changed; in 2014, several bills had already been tabled at Parliament, and John C. Major, former justice of the Supreme Court who was on the bench for Sue Rodriguez, had publicly called Parliament to update legislation on the subject one year earlier.[12] Certain sociological realities had also shifted the context in Canada. One underlying theme that seemed to underpin the Supreme Court's reasoning is the limited reduction in suffering offered by the Canadian palliative care system.[13] Not only could a prohibition from seeking physician-assisted death when faced with a grievous and irremediable medical condition cause tremendous psychological trauma to a person, it

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[9] More specifically, Cory J agreed with Justice McLachlin's reasons stating that s. 7 was infringed, because "dying is an integral part of living, [and] is entitled to the constitutional protection provided by s. 7". However, he also agreed with Chief Justice Sopinka's disposition and s. 15 analysis in that it "can be applied to grant the same relief at least to handicapped terminally ill patients." *Supra* note 3, p. 630 and 631.

[10] He refers to this as the "right to die with dignity". *Supra* note 3, p. 630.

[11] *Ibid*, p. 526.

[12] D. McCue, *Assisted suicide laws need updating, says former Supreme Court justice*, CBC News, 25 October 2013, http://www.cbc.ca/news/assisted-suicide-laws-need-updating-says-former-supreme-court-justice-1.2251454, 10.12.2017.

[13] *Supra* note 1, para 23, 107.

could also push a person to take their own life sooner than they would if physician-assisted death were available.[14] It seems that the sociological, political and legal context in Canada was at a pivotal point, setting the stage for the Supreme Court to take a new stand on physician-assisted death in 2015.[15]

2. The *Carter* Case

2.1. Facts

Like Mrs. Rodriguez, Gloria Taylor had ALS. Propelled by the fear of living "in a bedridden state, stripped of dignity and independence",[16] she brought her claim to seek physician-assisted death before the British Columbia Supreme Court,[17] alongside the British Columbia Civil Liberties Association, Dr. William Shoichet,[18] Lee Carter and Hollis Johnson.

Lee Carter and Hollis Johnson are the daughter and son-in-law of Kay Carter, a woman who suffered from spinal stenosis, a non-fatal condition that compresses the spinal cord. Although surgery was an option to relieve some of the compression, Mrs. Carter declined due to significant risks associated with the operation. Like ALS, her body steadily deteriorated yet her cognisant functions remained intact. Mrs. Carter could not move without assistance and was confined to a wheelchair. In 2009, she decided to seek physician assisted death in Switzerland with the help of her daughter and son-in-law. In January 2010, she travelled to the DIGNITAS clinic in Switzerland, where she passed away peacefully, surrounded by her children.[19]

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[14] *Supra* note 1, para 90.

[15] For more on the political and legal context leading up to the *Carter* decision, see Dr. Harvey Max Chochinov (chair), Professor Catherine Frazee (panel member), and Professor Benoît Pelletier (panel member), *External Panel on Options for a Legislative Response to* Carter v. Canada*, Final Report*, 15 December 2015, p. 44 ("Federal Panel Report"), p. 32.

[16] *Supra* note 1, para 12.

[17] *Carter v Canada (Attorney General)*, [2012] BCSC 886.

[18] Physician based in Victoria, BC, who supports the constitutionalizing of physician-assisted death; *Ibid,* paras 72–76.

[19] *Supra* note 17, paras 57–71.

For Mrs. Carter, dying with dignity in Switzerland was an option as she had the financial capacity to do so.[20] That said, Lee Carter and Mr. Johnson, who planned and facilitated the trip, could technically have been prosecuted for aiding Mrs. Carter in acquiring physician-assisted death due to the *Criminal Code* provisions.[21] Additionally, although they were able to provide for a dignified death for Mrs. Carter in Switzerland, they claimed they should have been able to seek physician-assisted death without having to go through the grueling task of coordinating and taking the trip. They said Mrs. Carter ought to have been surrounded by all family and friends she wished, in Vancouver.[22]

Unfortunately, going to Switzerland was not an option for Mrs. Taylor as she did not have the financial means, which meant she could not seek physician-assisted death in Canada due to the *Criminal Code* provisions. Ultimately, she was left with the "cruel choice" of deciding between taking her own life while she was still physically capable of doing so, or forfeiting her ability to exercise any control over the manner and timing of her death.[23]

2.2. Trial & appeal

The trial judge had the daunting task of deciding whether the claimants had the constitutional right to seek physician-assisted dying. After reviewing a vast array of submissions from counsel, testimonies and expert witnesses, as well as the law in several foreign jurisdictions on the same matter,[24] the trial judge found that, although the adjudicative facts were similar in both cases,[25] both the s. 1 and s. 7 analyses along with the legislative context had changed since *Rodriguez,* thus allowing a lower

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[20] The cost of travel, accommodations, medical consultations and services acquired at DIGNITAS came up to approximately $ 32 000 CAD. See *supra* note 16, para 70.

[21] *Supra* note 1, para 17.

[22] *Supra* note 17, para 71.

[23] *Supra* note 1, para 13.

[24] *Supra* note 17, paras 114–115.

[25] *Ibid,* para 941.

court re-open settled case law of a higher court.[26] Justice Smith decided in favour of the claimants, declaring the blanket prohibition unconstitutional. She consequently declared a one-year suspension of the provision's invalidity to avert a legal void in anticipation of appropriate legislation. She also granted a constitutional exemption so Mrs. Taylor could seek physician-assisted death during the suspension of the declaration.[27]

On appeal, the majority[28] found the trial judge erred in declaring the blanket prohibition unconstitutional as she was still bound by the *Rodriguez* decision.[29] According to the BC Court of Appeal, although the analytical method of s. 7 was different in *Carter* compared to that of *Rodriguez* in 1993, the final result of both would be no different. The Supreme Court did not agree.

2.3. Supreme Court of Canada

Mrs. Carter's claim challenged the constitutionality of s. 14 and s. 241(*b*) of the *Criminal Code*.[30] Other provisions were included, however the Court found them not to be at the heart of the constitutional challenge.[31] When asked whether the provisions infringed s. 7 (right to life, liberty and security of the person), and s. 15 (equality rights) of the *Charter*, the Court found that sections 14 and 241(*b*) of the *Criminal Code* unjustifiably violated s. 7. For that reason, it did not proceed with a s. 15 analysis.[32]

The Court declared the provisions of no force or effect insofar as they prohibit physician-assisted death for competent and consenting adults who are suffering from grievous and irremediable medical conditions.[33]

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[26] *Ibid,* paras 946, 1002 and 1003. Also see *Carter* [2015] 1 SCR 331, para 28.

[27] *Supra* note 1, para 31 and 32. Also see *supra* note 16, para 1414.

[28] *Carter v Canada (Attorney General)*, 2013 BCCA 435.

[29] *Ibid*, paras 323, 324.

[30] *Criminal Code*, RSC 1985, c C-46.

[31] "Sections 21, 22, and 222 [of the *Criminal Code*] are only engaged so long as the provision of assistance in dying is itself an 'unlawful act' or offence. S. 241(*a*) does not contribute to the prohibition on assisted suicide." *Supra* note 1, para 20.

[32] *Supra* note 1, para 93.

[33] *Supra* note 1, para 127 and 147.

The Court suspended the declaration of invalidity for 12 months to give Parliament and provincial legislatures time to come up with a response.[34]

It should be noted that Mrs. Taylor passed away before the Supreme Court released the *Carter* decision, thus making the constitutional exemption remedy she sought (to seek physician-assisted death during the suspension of invalidity of the *Criminal Code* provisions) moot.[35] Despite this tragic outcome, the case remained extremely important for the constitutional and medical fields in Canada, as will soon be discussed.

2.4. Application of *stare decisis*

The Supreme Court agreed with the trial judge on many fronts. Firstly, regarding the ability to revisit the settled case law of *Rodriguez*, it found that, although the facts were similar in both cases and the principle of *stare decisis* (the rule of precedent) is a foundation of the common law,[36] it "is not a straightjacket that condemns the law to stasis". There are two exceptional situations which allow trial courts to reconsider settled rulings of higher courts: where a new legal issue is raised, and where there is a significant change in circumstances or evidence that "fundamentally shifts the parameters of the debate".[37] The Court concurred with the trial judge's conclusion; a "substantive change" to the s. 1 analysis, among other distinguishing factors,[38] provided an opening for the Court to decide differently.[39]

More specifically, the law surrounding s. 1 and s. 7 of the *Charter*, as well as the circumstances surrounding physician-assisted dying (including

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[34] *Supra* note 1, p. 336, 337, and para 126 and 132. The question of legislative authority over healthcare is discussed in the section "Concurrent jurisdiction".

[35] *Supra* note 1, para 129: because Mrs. Taylor had already passed away and none of the other litigants sought the constitutional exemption of the suspension of invalidity, the Court did not see fit to create that exemption.

[36] *Canada (Attorney General) v. Bedford*, [2013] 3 SCR 1101, para 38.

[37] Based on *Bedford*, *ibid*, para 42. Also see *supra* note 1, para 44.

[38] Including the fact that the majority in *Rodriguez* did not consider the right to life, the fact that overbreadth and gross disproportionality (principles of fundamental justice) had not been identified yet, and the fact that the majority "assumed" a s. 15 violation. See *supra* note 1, para 28.

[39] S. 1 analysis had changed since *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 SCR 567. See *supra* note 16, para 994, and *supra* note 1, para 28.

evidence that proves safeguards can be put into place), had evolved since 1993.[40] In the era of *Rodriguez*, there was no regulation of physician-assisted death anywhere in the world. Since then, however, several other jurisdictions had enacted legislation and/or legally recognized physician-assisted death in the courts including Oregon, the Netherlands, Belgium, Washington, Colombia and Montana.[41] Not only did the trial judge find that there were no significant abuses in these jurisdictions,[42] but the Supreme Court agreed that this evidence was sufficient to fundamentally shift the parameters of the debate, thus allowing lower courts to diverge from the *Rodriguez* precedent.

2.5. General values considered

Many values (competing or not) were considered in this case, including autonomy, dignity,[43] integrity, private life, self-esteem, and choice. Regarding choice, the law has come to recognize that, in certain circumstances, one must respect a person's choice regarding the end of their lives.[44] Before *Carter*, persons with grievous and irremediable medical conditions were deprived of the possibility of making a choice that could turn out to have an incredibly profound impact on their sense of dignity and personal integrity. This choice would be compatible with the values they have had all their lives, and would ultimately reflect the way they lived their lives.[45]

Alternatively, the protection of the vulnerable is the State's main concern; it mentions both abuse and the devaluation of human life as risks of a permissive regime. The government of Canada argues that the object of the prohibition is to preserve life no matter the circumstances.[46]

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[40] "[…] the law relating to the principles of overbreadth and gross disproportionality [have] materially advanced since *Rodriguez*", *supra* note 1, para 46; regarding the evolution of the "legislative landscape" since *Rodriguez*, see paras 7–9.

[41] *Supra* note 1, para 8. Also see *supra* note 10, p. 37.

[42] *Ibid*, paras 106 and 107.

[43] *Ibid*, para 2.

[44] *Ibid*, para 63.

[45] *Ibid*, para 65.

[46] *Ibid*, para 78.

With that said, the conception of a regime that protects socially vulnerable persons from anticipated abuses while allowing competent patients to choose the time and manner of their death is central to the Court's reasoning in this case.[47] To counter government of Canada's argument, the Court emphasizes that the protection of the vulnerable also means preventing them from being encouraged to take their own lives in moments of weakness.[48]

2.6. Section 7 – general

Although the Court tackles other important constitutional questions like the division of federal and provincial legislative powers in the health field,[49] the focus of the decision was on s. 7 of the *Charter*. The Court had to answer whether the prohibition against physician-assisted dying violated Gloria Taylor and Kay Carters' rights to life, liberty and security of the person, and if it was in accordance with the principles of fundamental justice. In the end, the Court decided that all three rights were violated and the total prohibition was overbroad, thus not in accordance with the principles of fundamental justice.[50]

The Court had to balance competing values. On the one hand, the "autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition"; and on the other hand, the necessity to protect the vulnerable.[51] The Court made sure to state that the right to life pursuant to s. 7 does not require an absolute prohibition on physician assistance in death, as this would create a duty, instead of a right, to live.[52]

In general, s. 7 emanates from a profound respect for the value of human life. It also englobes the life, liberty and security of a person during

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47 *Ibid*, paras 25 and 103.

48 *Ibid*, para 78.

49 *Ibid*, paras 49–53. For more on legislative authority, see section on concurrent jurisdiction.

50 More on the Court's analysis of the principles of fundamental justice can be found in the section entitled "Principles of fundamental justice".

51 *Supra* note 1, para 2.

52 *Ibid*, para 63.

their passage to death.[53] It recognizes the value of life and respects the role of autonomy and dignity at the end of life. Today, the right to life no longer requires that "all human life be preserved at all costs",[54] as was decided in *Rodriguez*. Indeed, the Court expressly stated that the law has, in certain circumstances, recognized an individual's choice about the end of their life, which is entitled to be respected.[55]

Considering the limitations of palliative care in reduction of suffering,[56] by depriving persons of this incredibly intimate choice as a reaction to unimaginable suffering, the Court held that the blanket prohibition violates one's right to life, liberty and security. It also deprives patients from the possibility of bringing a peaceful end to their lives at the time and manner of their choosing.[57]

2.7. Section 7 - the right to Life

The Court was very clear to state that a total prohibition deprives some individuals of their life. The Court noted that "the case law suggests that the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, *either directly or indirectly*."[58] Following the logic that a total prohibition could lead certain persons to take their lives earlier than they would have had physician-assisted dying been available, there is a certain threat or danger or exposure to a higher risk of death created by the blanket ban.[59]

Although the Court did not necessarily have to continue the s. 7 analysis once it found the right to life was violated, it nevertheless carried on and considered whether the right to liberty and security were at play.

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53 *Ibid*, para 63.

54 *Rodriguez*, *supra* note 3, per Sopinka J., p. 595.

55 *Supra* note 1, para 63.

56 For more on palliative care, see section "Other considerations".

57 *Ibid*, para 14.

58 *Ibid*, para 62 (our emphasis).

59 *Ibid*, paras 57, 58.

2.8. Section 7 – the right to Liberty

The right to liberty involves the right to be protected against state interference in personal medical or life decisions which are of fundamental importance.[60] Preoccupations relating to autonomy and quality of life are also rights under the right to liberty and security, as implied by the concern for protecting the autonomy and dignity of a person. Other factors under consideration are the protection from serious physical pain/suffering or psychological stress, being the master of one's own bodily integrity (which includes personal, physical or psychological) as well as the possibility of making decisions relating to one's course of treatment.[61]

Of note, informed consent is also a factor of consideration in this element. mentally capable persons can – and should – be able to make informed decisions relating to their physical state freely and without interference.[62] A person's right to decide their own fate allows them to dictate the course of their own medical treatment: this is the underlying principle of informed consent.[63] Following the aforementioned reasoning, the Court found that the right to liberty was engaged.

2.9. Section 7 – the right to Security of the Person

Once again, a person's autonomy over their own personal integrity is at the forefront of this right. Specifically preoccupying the Court within this facet of s. 7 are autonomy, dignity, and quality of life.[64] Any intrusion by the State on the physical or psychological integrity of a person, including any measure which causes physical suffering or psychological trauma, is a violation to the right to security of the person. The Court uses the same example of informed consent, wherein a mentally capable person should be able to freely make decisions regarding their own medical treatment; this decision represents a profoundly personal reaction to intense pain and

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[60] *Ibid*, para 30.

[61] *Ibid*, para 65 and 66.

[62] *Supra* note 1, para 68.

[63] On the concept of "informed consent", see the subsection entitled "Conditions".

[64] *Supra* note 1, para 64.

suffering, and no one should be deprived of this choice. Nor should a person be subjected to intolerable suffering due to a lack of choice. The right to security of the person was therefore engaged by the prohibition.

2.10. Principles of fundamental justice

As the Court states, s. 7 does not guarantee a lack of State interference with a person's right to life, liberty and security. Rather, it guarantees the State will not do so in a way that has grossly disproportionate consequences to the object of said interference or that is arbitrary or overbroad.[65] The analysis of a law's accordance with the principles of fundamental justice is not concerned with wide-ranging societal benefits or social interests; these are more appropriately considered under a s. 1 analysis.[66] In other words, the State cannot use societal interests to justify a violation in accordance with the principles of fundamental justice. The government of Canada attempted to do this with regards to overbreadth and gross disproportionality, however the Court rejected these arguments, stating the focus of the principles of fundamental justice was "not on the impact of the measure on society or the public, which are matters for s. 1, but on its impact on the rights of the claimant."[67]

The Court held that the total prohibition did not limit individuals' rights arbitrarily,[68] however it was overbroad in that it went too far by denying the rights of certain individuals who have no relation to the object of the law.[69] The Court refused to expressly decide on gross disproportionality, as it already held that the prohibition was too far-reaching. However, the Court did seem to agree with the trial judge's finding that the

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[65] *Ibid*, paras 71 and 72.

[66] Relying on the Court's opinion in *R. v. Swain*, [1991] 2 SCR 933, para 977. *Ibid*, paras 79 and 80.

[67] *Supra* note 1, para 89.

[68] There was a rational connection between the object of the law (protecting the vulnerable from ending their lives in times of weakness) and the limit it imposes on life, liberty and security of the person (the blanket ban "clearly helps achieve this object"). *Ibid*, paras 83 and 84.

[69] *Supra* note 1, paras 85 and 88.

prohibition's negative impact on an individual's right to life, liberty and security was very severe and grossly disproportionate to its objective.[70]

Finally, the appellants invoked the violation of the principle of parity (which requires offenders who have committed acts of comparable blameworthiness to be sanctioned of "like severity") as a principle of fundamental justice because the law punishes the provision of physician-assisted death with the sanction of culpable homicide, while exempting other end-of-life practices from any criminal sanction. Following the Supreme Court's jurisprudence which had yet to identify parity as a principle of fundamental justice, the Court rejected that argument.[71]

2.11. Risks of a permissive regime

It goes without saying that a number of risks arise in a permissive regime. However, as the trial judge reasoned (reasoning which the Supreme Court agreed with), a carefully developed and well-executed regime could reduce the inherent perils of physician-assisted dying and protect vulnerable persons from abuse or error.[72] Yet, the effect of strict limits per se seems to be of little consequence to the reduction of said risks.[73] It is ultimately up to Parliament and provincial legislatures to weigh and balance the viewpoint of those who could potentially be endangered by a permissive regime and those who wish to seek assistance in dying when developing a legislative framework. Guarantees must be carefully regulated and applied adequately.[74]

2.12. Conditions

The conditions set out by the Court are clear. First and foremost, the person seeking physician-assisted dying must be suffering from a grievous and irremediable condition. Before the Supreme Court's declaration

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[70] *Supra* note 1, para 90

[71] *Ibid*, paras 91 and 92.

[72] *Ibid*, paras 3, 105 and 117.

[73] *Ibid*, para 110.

[74] *Ibid*, paras 98 and 126.

on this issue, a person in a similar situation would be limited to the painful decision of either taking their own life or suffering through their ailment until they die naturally. As the Supreme Court so eloquently stated in the very first paragraph of its decision, "the choice is cruel".[75]

The Court sets out the conditions as follows: a person seeking physician-assisted dying must be (1) an adult who is competent, (2) who clearly consents to the termination of life, (3) who is affected by a grievous and irremediable medical condition (including an illness, disease or disability), (4) and who has a condition that causes enduring suffering that is intolerable to the individual in the circumstances of his condition. In addition to these, two other conditions arise from the judgment: (5) informed consent,[76] and (6) the voluntary choice of physician-assisted dying.[77]

On the one hand, some may contend that these two last conditions are already included in the first four. On the other hand, it could be argued that clear consent and informed consent are not the same thing and should be distinguished as their own conditions.[78] For example, the trial judge in *Carter* took special care in defining "informed consent" in the medical law field as meaning "an intelligent choice as to *treatment options* made after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options."[79] Clear consent can be interpreted as permission that has been clearly expressed as opposed to unclearly expressed.[80]

Both the trial judge and the Supreme Court use the informed consent standard to confirm that proper care is taken to ensure the patient is educated on their diagnosis and prognosis, and that "*[all] treatment options described* included all reasonable palliative care interventions."[81] Although not particularly developed by the Court, it seems that before a patient

[75] *Ibid*, paras 1 and 13.

[76] *Ibid*, paras 27 and 106.

[77] *Ibid*, paras 4 and 127.

[78] On informed consent, see *Reibl v. Hughes*, [1980] 2 SCR 880, p. 895.

[79] *Supra* note 17, para 43, citing *Malette v. Shulman* (1990), 67 DLR (4th) 321 (Ont. C.A.), 327 (our emphasis).

[80] *Supra* note 78, p. 886–888. On the duty of disclosure, see *Hopp v. Lepp*, [1980] 2 SCR 192, p. 210.

[81] *Supra* note 1, para 27 and 106 (our emphasis).

makes their decision on physician-assisted dying, they must be presented with all possible alternative solutions by their physician.

The choice must also be voluntary. This means the decision must be made in the absence of outside pressure including familial pressure or undue influence, which necessarily refers to the subject of vulnerability. For the purposes of this analysis, a vulnerable person could be a person who submits to pressure that has been exercised on them or, alternatively, a person feeling pressure from their perception of being a burden on society or their family.

2.13. Other considerations

The values at stake in this case include a person's autonomy, personal integrity, dignity, privacy, self-esteem, the sanctity of life and the respect for the choice of a person regarding the end of their life. Throughout the decision, the Court uses a panoply of different ways to express a key principle of the decision, which is that people have the right to choose how they will die. The Court also considers the risk that vulnerable persons may be caught up in physician-assisted dying and the fundamental importance of protecting them. However, the Court also agrees with the trial judge's finding on how the existence of permissive regimes in other jurisdictions does not necessarily have an inordinate impact on socially vulnerable persons.[82]

To diminish these risks, the Court approves the trial judge's suggestion of a "carefully designed and monitored system of safeguards",[83] via a rigorous and well-run regulatory framework, among other things. The Court says the regulatory regime must be scrupulously surveyed.[84] Certain believe there must be two separate watch-dog organisms to capture the effect on society as well as collect data.[85] Nevertheless, the Court did not include this in its discussion.

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[82] *Supra* note 1, para 107.

[83] *Ibid*, para 117.

[84] *Ibid*, para 27.

[85] Different groups consulted by the Federal panel seemed to agree on the need for adequate oversight of physician-assisted death. See *supra* note 15, p. 109.

The Court also speaks of a balance between access to physician-assisted dying and the protection of vulnerable persons. Indeed, the Court uses a balance – and not a hierarchy – to seek an equilibrium between these competing values, which the responsibility lies with Parliament and provincial legislatures.[86]

Regarding palliative care, the Court recalled the trial judge's findings that in some cases palliative care had improved after the implementation of a permissive regime.[87] Addressing the effectiveness of palliative care in Canada, the Canadian Cancer Society has described it as a "patchwork of service", "inconsistent and inadequate", claiming critically ill patients "fall through the cracks" due to the lack of quality, availability and standardization across Canada.[88] Without making explicit statements on the subject, the Court does mention the limited reduction in suffering offered by palliative care as an argument used by proponents of physician-assisted death.[89] The Court also considers the possibility that a person could desire to end their lives prematurely if physician-assisted death were not available.[90]

Regarding vulnerable persons, in analysing the guarantees flowing from s. 7, the Court does not go as far as saying that the right to life includes the right to a quality of life.[91] The Court agrees with the trial judge's rejection of the qualitative approach and confirms that the right to life is only engaged by the risk of peril; in other words, the right to life is the right not to be exposed, directly or indirectly, to the threat of death.[92]

Finally, the Court does not place a limit in its conditions to those who are at the end of their lives. It also does not place a limit to physical medical problems. Finally, the Court uses the term "suffering" as opposed

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[86] *Supra* note 1, paras 53, 98, 115 and 126.

[87] *Ibid*, para 107.

[88] *Palliative care in critical condition: Canadian Cancer Society*, *The Canadian Press*, 12 January 2016, http://www.cbc.ca/news/health/palliative-care-1.3400369, 10.12.2017. Also see *Canada failing on palliative care*, *thestar.com*, 18 February 2015.

[89] *Supra* note 1, para 6.

[90] *Ibid*, paras 57–58.

[91] Instead, quality of life has generally been treated as a liberty and security right. *Supra* note 1, para 62.

[92] *Supra* note 1, para 62.

to "pain". "Suffering" implies a larger definition and social connotation which the term "pain" does not contain.[93]

2.14. Concurrent jurisdiction

The 1995 Supreme Court decision of *RJR MacDonald* confirmed that health is an area of concurrent jurisdiction, where both Parliament and provincial legislatures can validly legislate on the subject.[94]

In *Carter*, the appellants invoked the doctrine of interjurisdictional immunity to argue that the *Criminal Code* provisions cannot apply to physician-assisted death, as it lies at the core of provincial jurisdiction over healthcare under s. 92(7), (13), and (16) of the *Constitution Act, 1867*.[95] According to the appellant's and interveners' respective factums, the proposed core is the "power to deliver necessary medical treatment for which there is no alternative treatment capable of meeting a patient's needs", or, as Quebec described it, "the power to establish the kind of health care offered to patients and supervise the process of consent required for that care".[96] The Court rejects this argument, relying on *Canada (Attorney General) v. PHS Community Services Society*,[97] which states that Parliament has legislative authority over criminal law that touches on health, including prohibiting medical treatments that are dangerous or perceived as socially undesirable.[98] Accordingly, the Court concluded that provincial power to legislate over health cannot exclude federal legislation over physician-assisted death.[99]

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[93] *Ibid*, para 5.

[94] *RJR MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 SCR 199, para. 32. Also see *Carter*, *supra* note 1, para 53.

[95] *Supra* note 1, para 49.

[96] *Supra* note 1, para 52.

[97] [2011] 3 SCR 134.

[98] *Ibid,* para 68.

[99] *Supra* note 1, para 53. It should be noted that, although the Court mentions both Parliament and provincial legislatures throughout the decision, it seems to impose the obligation to legislate on Parliament only: "Parliament faces a difficult task […] it must weigh and balance the perspective of those who might be at risk in a permissive regime against that of those who seek assistance in dying […]. The degree of deference owed to Parliament, while high, is […] reduced.", para 98.

Aside from Parliament and provincial legislative authority, there is also the factor of physician's colleges to consider. The Court is explicit in stating that, following its decision, physicians are under no obligation to provide assistance in death, even if it is in their patients' best interest.[100] Indeed, the Court seemed to heed the request from several interveners[101] regarding protecting physicians' freedom of conscience and religion. Although the Court leaves the development of a legislative scheme to Parliament and provincial legislatures, it makes sure to indicate the imperative of reconciling physicians' and patients' *Charter* rights and protecting physicians who provide assisted death as well as those who conscientiously object.[102]

Regarding the role of physicians in assessing patients seeking assisted death, the Court considers their current role in evaluating the capacity of patients who make decisions regarding their course of treatment. The Court seems to see it as a continuum within the established current practice, which is "part and parcel of [the Canadian] medical system". Essentially, it sees no difference in vulnerability between patients who refuse or request the withdrawal of life-saving treatments, patients who request palliative sedation, and those who seek physician-assisted death.[103]

Before concluding the discussion on *Carter*, it is important to mention several questions that arise regarding mental illness, minors and advance requests for physician-assisted death. Regarding psychological conditions, it is certain that suffering has physical and psychological elements. But can the grievous medical condition itself be strictly psychological? In interpreting the conditions set forth by the Supreme Court, it seems that purely psychological medical conditions could fall within the scope of *Carter*, as long as they are serious, irremediable and conform to the other parameters of the decision. In that respect, if a s. 15 *Charter* challenge

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[100] *Ibid*, para 132.

[101] Including the Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project, the Catholic Health Alliance of Canada, and the Canadian Medical Association. See *Carter*, *ibid,* paras 130 and 131.

[102] *Ibid*, paras 131 and 132.

[103] *Ibid*, para 115.

were to be brought forward, it is our opinion that the Court should see no difference between physical and mental illness.[104]

Concerning minors, it is clear that the Court did not include them in its decision because it refers to competent adults only throughout its reasons. However, that does not mean minors will not eventually be considered. For now, *Carter* does not oblige Parliament and provincial legislatures to allow physician-assisted death to minors, but does that mean either level of government cannot provide physician-assisted death to minors by law? If this were to happen, an argument could be made that legislation providing physician-assisted death to minors would be valid, as *Carter* is a bottom line.[105] In other words, if government were to go beyond *Carter* in favour of physician-assisted death, it would likely be constitutional. Certainly, the Court did not include minors in its decision, however legislation that is more "generous" than *Carter* with respect to minors could be valid.

As for advance requests, the Court does not discuss this element, and it seems it does not fall within the scope of the decision.[106] For clarity, an advance request can include a person designating a proxy to make decisions including physician-assisted death in case of a future patient's incapacity. If a challenge or legislation were to be put forward for advance requests, the *Carter* precedent would most likely not support it, considering the emphasis the Court places on decisional capacity (capacity to consent is one of the conditions). There does not seem to be any intention from the Court to include advance requests in its reasons, and importance is placed on the decisional capacity of a patient at the time of the request for physician-assisted death (which takes place momentarily following said request), as opposed to, for example, ten years before the performance of the act.

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[104] As long as they are serious and irremediable, and fall within the *Carter* conditions. However, this statement is made "under reserve" of the Court's very slight insinuation that psychological illnesses are excluded, in light of Professor Montero's affidavit, which is discussed in section "Federal legislation".

[105] See B. Pelletier, *Les deux solitudes juridiques*, *La Presse*, 30 April 2016, http://plus.lapresse.ca/screens/d7d54a74-8744-4271-9b51-3e58f921d635%7C_0.html, 10.12.2017.

[106] *Supra* note 1, para 127.

3. Quebec legislation

Before the *Carter* decision, Quebec had already begun to legislate on physician-assisted death, or medical aid in dying, as it is referred to. The initiative was launched in 2009 and an ad-hoc *Select Committee on Dying with Dignity* ("Select Committee") held public consultations on the subject in February and March 2010.[107] Once the consultations concluded, the legislative assembly held a number of hearings with the Select Committee.[108] In March 2012, the Select Committee published their report entitled *Mourir dans la dignité*, or *Dying with Dignity*. In the first half of the report, the Committee makes a number of recommendations regarding reinforcing and refining current end-of-life practices including palliative care and palliative sedation. In the second part of the report, the Select Committee recommends legal recognition and regulation of medical aid in dying in Quebec.[109]

Following these findings, the National Assembly of Québec began working on bill nº 52, entitled *Loi concernant les soins de fin de vie*. The *Act Respecting End-of-Life Care* ("Quebec Act") received royal assent 10 June 2014 and came into force 10 December 2015. It modified the *Civil Code of Québec*,[110] the *Code of Civil Procedure*,[111] and other provincial laws.[112] Although the legislation only came into force after the *Carter* decision, it is important to note that the legislative process began before.

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[107] Quebec, Legislative Assembly, *Journal des débats de la Commission de la santé et des services sociaux, Étude des crédits budgétaires 2011-2012 du ministère de la Santé et des Services sociaux, volet Santé*, 39th Leg, 2nd sess, Vol 42 No 7 (12 April 2011) (Mme Maryse Gaudreault), http://www.assnat.qc.ca/fr/travaux-parlementaires/commissions/csss-39-2/journal-debats/CSSS-110412.html, 10.12.2017.

[108] Quebec, Legislative Assembly, *Journal des débats de la Commission de la santé et des services sociaux, Étude des crédits budgétaires 2011-2012 du ministère de la Santé et des Services sociaux, volet Santé*, 39th Leg, 2nd sess, Vol 42 No 6 (22 March 2011), http://www.assnat.qc.ca/fr/travaux-parlementaires/assemblee-nationale/39-2/journal-debats/20110322/33763.html, 10.12.2017.

[109] Commission spéciale, *Mourir dans la dignité*, *Rapport de l'assemblée nationale du Québec*, March 2012, p. 101.

[110] CQLR c CCQ-1991.

[111] Then CQLR c C-25, which has now been replaced by CQLR c C-25.01.

[112] The *Medical Act*, CQLR c M-9, the *Pharmacy Act*, CQLR c P-10, and *An Act Respecting Health Services and Social Services*, CQLR c S-4.2.

This means the *Criminal Code* provisions were still constitutional at the time the Quebec government expressed interest in legislating on the subject. However, Quebec seemed to interpret voluntary euthanasia as a matter of healthcare, which is, in its opinion, an area of exclusive provincial competence,[113] as opposed to a matter of pure criminal law, which is of federal legislative competence. Indeed, considering the title and s. 1 of the Quebec Act,[114] the provincial legislature seems to have linked medical aid in dying to the end-of-life healthcare "continuum"[115] in order to avoid conflict with the *Criminal Code* provisions against assisted suicide and voluntary euthanasia.

For this reason, it is important to note that the Quebec Act only provides for voluntary euthanasia – which, because of the necessity of medical intervention, has been linked to healthcare. The Quebec Act does not provide for assisted suicide. In other words, administering the substance is not left to the patient's discretion, which could open the door to a number of risks; it is the doctor who administers the lethal dose and supervises until death ensues.[116] Regardless, *Carter* decriminalized physician-assisted death, which includes both assisted suicide and voluntary euthanasia.

Carter also confirmed the Quebec Act in its introduction,[117] but it should be noted that the Quebec Act exclusively provides for medical aid in dying to people who are at the end of their lives,[118] whereas *Carter* does

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[113] *Supra* note 30, s. 92(7), (13), and (16).

[114] "The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.
In addition, the Act recognizes the primacy of freely and clearly expressed wishes with respect to care, in particular by establishing an advance medical directives regime."

[115] *An Act Respecting End-of-Life Care*, RSQ c S-32.0001, s. 1 ("Quebec Act").

[116] *Ibid*, s. 3(6) and s. 30.

[117] *Supra* note 1, para 7.

[118] *Supra* note 115, s. 26(3).

not necessarily limit availability of physician-assisted death to end-of-life patients, as already discussed.[119]

That being said, s. 26 of the Quebec Act enumerates all the conditions a person must meet in order to seek medical aid in dying. The patient must be an insured person within the meaning of the *Health Insurance Act*, be an adult who is capable of giving consent to healthcare,[120] be at the end of life, be suffering from a serious and incurable illness, be in an advanced state of irreversible decline in capability, and be experiencing constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

The physicians must also meet a number of requirements, listed at s. 29. First and foremost, they must make sure the patient requesting medical aid in dying meets all the conditions at s. 26, mentioned above. The physicians must make sure the patient is making the request freely (not as a result of external pressure), and that the request is informed.[121] The physicians must also verify the persistence of suffering and ensure the repeatedly expressed wish to obtain medical aid in dying remains unchanged over a period of time.[122] They must discuss the patient's

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[119] Although the Legislative background of the federal Bill C-14 states the *Carter* trial judge, Justice Smith, adopted a similar end-of-life criterion of the Quebec Act, it could be argued that "an advanced state of weakening capacities, with no chance of improvement" does not necessarily mean that the person is at the end of their life. See Minister of Justice and Attorney General of Canada, *Legislative Background: Medical Assistance in Dying (Bill C-14)*, p. 19, http://www.justice.gc.ca/eng/rp-pr/other-autre/ad-am/index.html, 10.12.2017. Also see *Carter, supra* note 17, paras 867, 1391.

[120] I.e. be able to understand the situation and the information given by health professionals, and to make decisions.

[121] The physician informs the patient of the prognosis and of other treatment options and consequences. *Supra* notes 78 and 80.

[122] According to s. 29(1)(*c*), the physician must "verify[…] the persistence of suffering and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition". See note 151. Also see B. Pelletier, *Les deux solitudes juridiques*, *La Presse.ca*, 30 April 2016, http://plus.lapresse.ca/screens/d7d54a74-8744-4271-9b51-3e58f921d635%7C_0.html, 10.12.2017. However, following a letter from the Quebec Minister of Health, Gaétan Barrette, informing health professionals of the new *Criminal Code* provisions, directors of healthcare institutions are advised to give a 10-day leeway period between requests for medical aid in dying and the administration of the treatment. The letter also recommends medical professionals to require two witnesses to sign off on requests, as per the federal Act. See L. Gagné, *Aide à mourir: Québec a modifié la loi en catimini, dénonce le PQ*, *canoe.ca*, 18 July 2016.

request with any members of the care team who are in regular contact with the patient as well as with the patient's close relations and ensure the patient has had an opportunity to discuss the request with the persons they wished to contact. Finally, the physician must obtain the opinion of a second independent physician, confirming that the conditions for obtaining medical aid in dying are met.

The Quebec Act also provides for the possibility of physicians to conscientiously object to administering or taking part in medical aid in dying due to their personal values. Those who refuse must provide continuity of care to the patient in accordance with the provisions of their code of ethics and the patient's wishes. They must notify the authorities responsible, which will have to take the necessary steps to find, as soon as possible, another physician willing to deal with the request.[123]

On that note, mention should be made of institutional objections, i.e. establishments which refuse to provide medical aid in dying for religious or other conscientious reasons. The Quebec Act does not seem to provide insight; although a Doctor has the ability to conscientiously object, the same cannot be said of facilities, like palliative care providers, for example. The SCC does not cover this, but the Quebec Minister of Health and Social Services, Gaétan Barrette, has publicly stated that institutions in his province must respond to requests to die with dignity and, if individuals conscientiously object, the institution must find another doctor to provide treatment.[124]

Comparatively speaking, the *Carter* decision is a departure from the Quebec Act for a number of reasons. As seen above, an argument could be made that *Carter* does not only apply to those who are at the end of their lives, whereas the Quebec Act requires the physician to submit a prognosis report stating the end-of-life of the patient, as opposed to a diagnostic report.[125] In other words, among the Supreme Court's

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[123] *Supra* note 115, s. 31.

[124] *Gaétan Barrette insists dying patients must get help to ease suffering, CBC News*, 2 September 2015, http://www.cbc.ca/news/canada/montreal/ga%C3%A9tan-barrette-insists-dying-patients-must-get-help-to-ease-suffering-1.3213615, 10.12.2017.

[125] *Supra* note 115, s. 29(1)(*b*).

conditions in *Carter*, which involve a grievous and irremediable medical condition, end-of-life does not seem to emerge. Practically speaking, a person could be suffering from a grievous and irremediable condition causing unbearable suffering, yet have a life expectancy of many years – such was the case for Kay Carter, who was suffering from a non-fatal condition.

As said before, *Carter* includes assisted suicide and voluntary euthanasia whereas the Quebec Act only provides for the latter. On this point, no serious objections have been made in the legal community.

Finally, the Quebec Act does not, *a priori*, require the unbearable suffering to be caused by the medical condition. As will be discussed in the next section, Parliament's[126] legislative response does require a causal connection between the suffering and the medical condition.

Both Carter and Parliament require a causal connection, however death does not have to be caused by the condition, but rather a decline in capacity.

4. *Carter* [2016]

Carter declared a suspension of declaration of constitutional invalidity for 12 months. Parliament was not able to meet that timeline due to the federal election, so the Attorney General of Canada brought a motion before the Supreme Court requesting a six-month extension on 11 January 2016. Four days later, the Supreme Court granted the motion in part. The majority ordered an extension of the suspension, but only for four months, to cover the delay caused by the election.[127]

Despite the 2016 *Carter* decision, after the expiration of the Supreme Court's declaration of invalidity on 7 June 2016, there seemed to be confusion about the legality surrounding physician-assisted death in anticipation of federal legislation. Certain provincial Attorney Generals announced that physicians providing assisted death to persons meeting

[126] Of note, in certain areas of *Carter*, the Supreme Court only refers to Parliament.

[127] *Carter v. Canada (Attorney General)*, [2016] 1 SCR 13, para 2 and 7 ("2016 *Carter* decision").

the *Carter* criteria would not be prosecuted.[128] The Ontario Ministry of Health stated the provincial government would cover the cost of the drugs used.[129] The College of Physicians and Surgeons of Ontario developed an interim policy on medical assistance in dying.[130] The Ontario premier confirmed that patients seeking physician-assisted death do not need to acquire court orders in order to protect themselves or their physicians from legal risk.[131] Nonetheless, a number of regulatory bodies of nurses and pharmacists urged practitioners to have court orders before providing treatment.[132]

In Ontario, the Superior Court of Justice declared that until the appropriate legislation came into force, persons seeking physician-assisted death needed court orders in order to exercise their constitutional right – not to seek authorization for a constitutional exemption – but rather to obtain a constitutional remedy under s. 24 of the *Constitution Act, 1982*,[133] pending the enactment of legislation.[134]

That being said, the Court stated that the Quebec Act can continue to apply in Quebec. The majority was very clear in stating those who wish to seek physician-assisted death in other provinces may apply to the superior court of their jurisdiction for relief during the extended period of suspension.[135]

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[128] Newfoundland and Labrador, Public Prosecutions Division, *Physician-Assisted Death (PAD)*, 9 June 2016, http://www.justice.gov.nl.ca/just/publications/pdf/dpp_practice_directive.pdf, 10.12.2017. Also see *supra* note 127, para 10, for the Quebec Minister of Justice; *O.P. v Canada (Attorney General)*, 2016 ONSC 3956, para 18, for the Attorney General of Ontario.

[129] S. Ubelacker, *Who will pay for the drugs for physician-assisted death?*, *The Canadian Press*, 12 June 2016, http://www.ctvnews.ca/health/who-will-pay-for-drugs-for-physician-assisted-death-1.2942509, 10.12.2017.

[130] The College of Physicians and Surgeons of Ontario, *Medical Assistance in Dying*, June 2016, http://www.cpso.on.ca/Policies-Publications/Policy/Interim-Guidance-on-Physician-Assisted-Death, 10.12.2017.

[131] *Physician-assisted death in Ontario comes with a legal caveat*, *CBC News*, 6 June 2016, http://www.cbc.ca/news/canada/toronto/ontario-physician-assisted-death-1.3618659, 10.12.2017.

[132] *O.P. v Canada (Attorney General)*, *supra* note 128, paras 19–21.

[133] *The Constitution Act, 1982*, Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[134] *Supra* note 127, paras 9, 24.

[135] *Ibid*, para 6.

5. Federal legislation

The Federal Bill entitled *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*[136] ("Act") received royal assent 17 June 2016. As its title suggests, it amends the *Criminal Code* to protect physicians and nurse practitioners who assist with death from being charged for culpable homicide.[137] As seen before, this goes beyond *Carter*, which did not cover nurse practitioners; that said, this deviation does not seem unconstitutional, because *Carter* constitutes a platform and not a ceiling for physician assisted death.[138]

Moreover, it seems the main premise behind including nurse practitioners is the fact that they have the authority to provide many of the same services as family physicians in assessing, diagnosing, and treating patients; it would be logical to protect them from criminal prosecution as well.[139] Thus, Parliament opted for the term "medical aid in dying", as opposed to a term that would only apply to physicians. In that respect, it seems that, in time and following a gradual change in culture surrounding this controversial issue, the term employed by Parliament will prevail over "physician-assisted death" in public discourse.

On that note, with regards to different terms used (as seen above, Parliament employs the term "Medical assistance in dying" in the Act, whereas the Ontario college of physicians and surgeons uses "Physician-assisted death", and Quebec uses "Medical aid in dying" in its legislation),[140] the trial judge in *Carter* states that all are generic terms

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[136] SC 2016, c 3.

[137] *Supra* note 30, s. 227.

[138] *Supra* note 105.

[139] Canada, Parliament, *House of Commons Debates,* 42nd Parl, 1st sess, No 45 (22 April 2016), p. 1230 (Hon. Jane Philpott), http://www.parl.gc.ca/HousePublications/Publication.aspx?Pub=Hansard&Doc=45&Parl=42&Ses=1&Language=E&Mode=1#8881567, 10.12.2017.

[140] According to the Ontario Supreme Court, opponents use the term "physician-assisted suicide", whereas proponents use the term "physician-assisted death", *O.P. v Canada (Attorney General)*, 2016 ONSC 3956, para 27. However, physician-assisted death can be separated into two sub-categories: voluntary euthanasia and assisted suicide. The main difference between the two lies in the role the physician plays; in the former, it is the physician who delivers the lethal substance to the patient. In the latter, it is the patient who performs the act to end their life (for example, taking a pill). *Supra* note 15, p. 44.

used to describe physician-assisted suicide or voluntary-euthanasia that is "performed by a medical practitioner or a person acting under the direction of a medical practitioner."[141] This seems to be in line with the Act.

But the debate on terminology does not end there. In other words, what should "it" be called? For the Supreme Court, although not expressed as directly, physician-assisted death is a medical act. Some call it "care".[142] Even though the Court did not use the word "care", it follows that a certain compassion for the terminally ill and suffering is a major component of this decision. Others say it is not medical simply because it is offered by doctors. Attention must be paid to this detail, as "care" is generally supposed to improve a condition. Nevertheless, the Court uses the terms "treatment" and "practice", which refers to the medical aspect of physician-assisted death.[143]

As part of Parliament's legislative response to *Carter*, an ad-hoc federal panel was created in order to provide background on medical aid in dying in Canada. One aspect which the federal panel addressed in their report is the diverse terms used by organisations[144] to describe physician-assisted death. Different concerns were brought forward by contributors; some suggested the term "death" indicates an event rather than a process.[145] Others raised indigenous concerns with the term "physician-assisted suicide" as it explicitly associates assisted death with physicians, which could cause apprehension that patients must "engage […] with their physician as a matter of course".[146] Others described the risk that "physician-assisted death or dying" could undermine the practice of palliative care, or that the term "assisted" is too emotionally charged and

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[141] *Supra* note 17, para 39.

[142] *Ibid*, para 7.

[143] *Ibid*, paras 23, 27, 52, 107.

[144] *Carter* uses "physician-assisted death" or "physician-assisted dying", Parliament employs the term "Medical assistance in dying" in the Act, the Ontario College of Physicians and Surgeons uses "Physician-assisted death", and Quebec uses "Medical aid in dying" in its legislation.

[145] *Supra* note 15, p. 47.

[146] *Supra* note 15, p. 46.

could be replaced with "administered".[147] Nonetheless, it is clear that this subject is a challenging issue for all Canadians.

Now that the Act has come into force, s. 241.1 of the *Criminal Code* defines medical assistance in dying as "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (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 […]." Although the Act was inspired by the Quebec Act, on this point it is a departure as the former includes both voluntary euthanasia and assisted suicide, whereas the latter does not, as seen above.

The conditions for seeking out medical assistance in dying are outlined at s. 241.2 of the *Criminal Code*; the person must be eligible for public health services, be at least 18 years old, make a voluntary request and give informed consent to receive medical assistance in dying, and have a serious and incurable illness, disease or disability. Subsection 241.2(2) defines a grievous and irremediable medical condition as being in an advanced state of irreversible decline in capability, experiencing enduring and intolerable suffering as a result of the medical condition, and where natural death is reasonably foreseeable, without a prognosis necessarily having been made.[148] On this, the Act differs from the Quebec Act on two fronts. The Act seems more flexible in that it does not require patients to be at the end of their lives, but requires death to be reasonably foreseeable, and does not require a prognosis.

The safeguards are provided at subsections 241.2(3) to (9). To name a few, patients' natural death must be reasonably foreseeable and the person must be in an advanced stage of decline in capacity. Patients must make a written request for medical assistance in dying (a designated person can do so if the patient cannot write), and have it signed by two independent witnesses. This differs slightly from the Quebec Act, which requires patients to be at the end of their lives and be in the advanced

[147] *Supra* note 15, p. 46.

[148] *Supra* note 30, s. 241.2(1) and (2).

stages of decline in capacity. The Quebec Act also requires only one witness (either a health or social services professional).[149] Although the conditions regarding the end-of-life are very similar, they are subtly nuanced.

Furthermore, two independent physicians or authorized nurse practitioners are required to evaluate the request, and there is a mandatory period of at least 10 days of reflection between the formal request and the date of treatment, unless death or loss of capacity to consent is imminent. This is in opposition to the undefined period of verification of the patient's persistence in the Quebec Act;[150] however, it is now subject to the letter written by the Quebec Deputy Minister of Health advising Quebec healthcare professionals to adhere to the 10-day period and two witness standards provided by the federal Act.[151] Finally, the Act provides for patients' ability to withdraw their request at any time.

The Act also seems to provide for a monitoring and reporting mechanism for medical assistance in dying. Parliamentary documents reveal an intention to work with provinces and territories on a voluntary protocol for the collection of data: "This is an issue that will require close co-operation with the provinces and territories, and [will be developed] in consultation with those governments."[152] That being said, there does not seem to be a specific mechanism currently in place.[153]

Regarding the condition of patients seeking medical assistance in dying, two deductions can be drawn from the Act: firstly, there does not have to be a specific prognosis or prospected time before death (although

[149] *Supra* note 115, s. 26.

[150] Which uses the "reasonably spaced intervals given the patient's condition" standard. *Supra* note 122 and s. 29(1)(*c*) of the Quebec Act.

[151] *Supra* note 115.

[152] Canada, Parliament, *House of Commons Debates,* 42nd Parl, 1st sess, No 45 (22 April 2016), p. 1230 (Hon. Jody Wilson-Raybould), p. 1010, http://www.parl.gc.ca/HousePublications/Publication.aspx?Pub=Hansard&Doc=45&Parl=42&Ses=1&Language=E&Mode=1#8881567, 10.12.2017.

[153] In Ontario, the College of Physicians and Surgeons has placed emphasis on current medical record obligations that existed before the legalization of medical aid in dying as an interim measure until regulations are developed on the reporting and collection of data on medical aid in dying. See the Ontario College of Physicians and Surgeons website: http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Assistance-in-Dying, 10.12.2017. Also see C. Cullen, *More than 100 Canadians have opted for assisted death since law passed*, *CBC News*, 2 September 2016, http://www.cbc.ca/news/politics/assisted-dying-tracking-numbers-1.3744347, 10.12.2017.

it would have to be reasonably foreseeable). Secondly, mental illness cannot be the sole medical condition suffered by the patient.

It seems that both diverge from *Carter*, as nothing in the Supreme Court's reasons unequivocally suggest an intention to limit accessibility of physician-assisted death to those who are at or near the end of their lives, or those with mental illnesses (as the sole medical condition and not resulting from suffering) as long as they satisfy the conditions set out in the decision.[154] Furthermore, if Parliament were to rely on the argument that the Court limits its decision to cases like Mrs. Carter's in order to support the condition for reasonable foreseeability of natural death provided for by the Act, that argument would be flawed. Mrs. Carter was suffering from a non-fatal medical condition, and the Court limited its decision to cases of the like, which does not impose the condition of reasonable foreseeability of natural death.[155]

Regarding the Act's requirement for a decline in capability,[156] *Carter* does not explicitly mention this condition. Indeed, where *Carter* talks about a grievous and irremediable medical condition, the Act provides that the person seeking treatment must be in an advanced state of irreversible decline in capability. Parliament seems to rely on paragraph 127 of the decision to limit the application to persons with similar conditions as Mrs. Carter and Mrs. Taylor, and Parliament opted for reasonable foreseeability of end of life and irreversible decline in capabilities, which is not, for the reasons stated above, a fact-driven argument, considering Mrs. Carter was not suffering from a fatal condition. In fact, a strong argument could be made that Mrs. Carter would not have satisfied the reasonable foreseeability of end of life condition imposed by the Act. Regardless, Parliament has taken its position.

On mental illness, generally speaking, persons suffering from this type of condition do not endure a decline in physical capabilities, nor are they in a position where their natural death is reasonably foreseeable. For these reasons, Parliament has taken the position that mental illness

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[154] B. Pelletier, *L'argumentaire fédéral sur l'aide médicale à mourir*, *La Presse*, 7 June 2016, http://plus.lapresse.ca/screens/65b2ac2d-1638-47f8-acba-ba4d0dd78a6d%7C_0.html, 10.12.2017.

[155] *Supra* note 1, para 127.

[156] *Supra* note 136, s. 241.2(2)(*b*).

cannot be the sole medical condition in order for a person to be eligible for physician-assisted death.

Indeed, a number of possible interpretations of the Court's decision can be made. A liberal interpretation would generally stick to the grievous and irremediable medical condition which causes persistent and intolerable suffering, which leaves quite a bit of room for flexibility.

The Act takes a stricter approach, coupled with Parliament's unique interpretation of paragraph 127 of the decision which limits its application to cases like Mrs. Carter and Mrs. Taylor's. Building on this basis, the Act adds the conditions of reasonably foreseeable death and a decline in capability. As mentioned above, a mental illness would normally not engender a decline in physical capabilities or reasonably foreseeable death, and following this logic, if mental illness is the sole medical condition, it is excluded from the application of the Act. Once again, this argument is based on the hypothesis that both Mrs. Carter and Mrs. Taylor were facing reasonably foreseeable death, which is not the case. The *Carter* decision applies to any patient with a grievous and irremediable medical condition that causes ongoing and intolerable suffering. In our opinion, this includes mental illness, even when it is the sole underlying medical condition, insofar as the criteria outlined in *Carter* are met. It is quite possible that mental illness was included in paragraph 127 of the decision, however insanity or other mental conditions which remove a person's capacity for consent would naturally be excluded.

That being said, it is still difficult to determine whether the *Carter* decision really applies to mental illness; given the guiding principles of the Court's decision (autonomy, personal integrity and physical/psychological wellbeing, quality of life and human dignity), we are of the opinion that it could be just as applicable to patients suffering from mental illness as those with physical ailments. However, and in the spirit of full disclosure, the opposite argument could be made if one were to rely on the fact that mental illness – contrarily to a number of corporal conditions – does not cause a decline in physical capability, which is a key factor in the *Carter* decision.

Also, caution should be taken with this hypothesis in light of the Court's reasons surrounding Professor Montero's affidavit, which it says

is based on cases which do not "fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders […]."[157] That being said, this particular aspect remains ambiguous and no categorical conclusion on the inclusion of mental illnesses by the Court can be made.

Regarding enduring suffering, the Act provides certain flexibility; it states that a person has a "grievous and irremediable" medical condition when, in part, the illness, disease or disability or the state of decline causes the patient enduring and intolerable (physical or psychological) suffering. The criterion that natural death be reasonably foreseeable should be appreciated while taking into account all of the medical circumstances of the patient, and not just the medical condition. In the Act, there is no precise link between the illness, disease or disability and the end-of-life. It does not require the anticipated cause of death be the patient's medical condition, nor that the patient be dying from a fatal illness. Death does not have to be caused by the serious and incurable illness, disease or disability, and the cause of the foreseeable death does not have to be the medical condition of the patient. Furthermore, this will not necessarily be a fatal disease or condition; the decline does not have to be due to a condition that is fatal in itself.

Moving forward, the preamble of the Act commits Parliament to the exploration of medical assistance in dying for mature minors, advance requests and cases where mental illness is the sole condition. The Act also provides for a parliamentary review in 5 years.[158]

6. Conclusion

Legislation surrounding physician-assisted dying has been a long time coming. Even in 1993, certain justices of the highest Court in the country were not convinced of Parliament's inability to adequately regulate physician-assisted death. In his reasons, while dissenting Justice Lamer recognized the importance of distinguishing situations where a person is aided

[157] *Supra* note 1, para 111.

[158] *Supra* note 136, s. 10.

in their decision to commit suicide and those where a person is influenced by another to commit suicide, he rejected the argument that protecting the vulnerable must result in denying self-determination in other circumstances: "I remain unpersuaded by the government's apparent contention that it is not possible to design legislation that is somewhere in between complete decriminalization and absolute prohibition."[159]

Fast-forward twenty years later, in a very similar factual situation, it seems Justice Lamer's opinion was foreshadowing what was to come. In *Carter*, by declaring the *Criminal Code* provisions inoperative to the extent that they prohibit physician-assisted dying requested by an adult who is competent, who clearly (voluntary and informed) consents to the termination of life, is affected by a grievous and irremediable medical condition (including an illness, disease or disability), and who has a condition that causes enduring suffering that is intolerable to the individual in the circumstances of his condition, the Supreme Court officially decriminalized physician-assisted death in Canada.

It should be noted that *Carter* is authored by "The Court". Usually, decisions by the Supreme Court are authored by one or a few of the majority (who are identified), and any judges who wish to write dissenting opinions do so. In *Carter*, no one in particular is identified, which indicates the unequivocal consensus of all nine justices in the decision.[160] This is subtle yet significant in that it underscores the unanimous agreement on this particularly important constitutional question.

After the *Carter* decision, Parliament began to work on developing a response to the decision. Of these was the instatement of an external panel to conduct consultations on options for a legislative response to the decision.[161] Along with other studies,[162] the report of the external panel provided information which informed the progress of the federal bill.

One factor which remains to be discussed in *Carter* is the future debate on equality rights; in *Carter*, the Court did not pursue a s. 15 analysis, as it

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[159] *Supra* note 3, p. 568–569.

[160] *Supra* note 15, p. 36.

[161] *Ibid.*

[162] *Ibid*, p. 5.

was not necessary in light of its findings regarding s. 7. A possible future question is whether physician-assisted dying can be extended to minors,[163] people seeking advance requests and those whom mental illness is the sole underlying condition. If Parliament were to refuse these people from seeking physician-assisted death, it would be up to the Courts to determine if a s. 15 violation could be saved by s. 1 of the *Charter*. Until then, nothing can be assumed. Additionally, regarding mental illness, in light of the federal legislation, if a *Charter* challenge were to occur, the condition preventing a person with mental illness as their sole medical condition from seeking medical aid in dying could be declared invalid in a s. 7 analysis based on the *Carter* precedent, even before a s. 15 analysis would be necessary.

However, one thing is certain: The Court will not consider these factors overnight. That does not mean that the Court will not consider the possibility in the next ten to fifteen years. Perhaps, as was the case in *Carter*, the legislative landscape and context surrounding this issue will have evolved by the time the Court is presented with this question. Perhaps the Court will eventually conclude that suffering is suffering. Perhaps, in the future, physician-assisted dying will be available to minors, advance requestors and the mentally ill under certain conditions for the aforementioned reasons. For the time being, suffice it to say that the *Carter* decision goes quite far for most Canadians, who had yet to be initiated to physician-assisted death.

[163] More specifically, should it be available to minors who are capable of making medical decisions, or "mature minors", as the Act states in its preamble?

Summary

In 1993, a woman named Sue Rodriguez made a claim before the Supreme Court of Canada in order to be allowed, legally, to seek physician assistance in dying. She was suffering from ALS, and her prognosis was between two and fourteen months. Essentially, she did not want to end her life prematurely by committing suicide, yet she also did not want to experience the slow and painful death which ALS would inevitably impose.

The Supreme Court has long recognized the notions of human dignity, personal autonomy and the ability to control one's physical and psychological integrity free of state interference as values falling under the scope of s. 7 of the *Canadian Charter of Rights and Freedoms*. However, in 1993, Canadian society had not seemed to come to a consensus regarding the decriminalization of physician-assisted suicide let alone the constitutionality of an active or passive regime. It was therefore not surprising that the Supreme Court delivered a divided decision in Rodriguez, with five out of nine judges opting for a more cautious approach, prioritising human life and protection of the vulnerable.

Despite the division in Rodriguez, legal recognition of physician-assisted dying would not be on the horizon until two decades later, when the highest court in Canada was presented once again with the question of whether the blanket prohibition provided by s. 241(b) was unconstitutional – but in a different Canadian context compared to that of 1993.

As it is discussed in this paper, it seems that the sociological, political and legal context in Canada was at a pivotal point, setting the stage for the Supreme Court to take a very different – and unanimous – stand on physician-assisted death in 2015.

Keywords: Charter, Medical assistance in dying, Rodriguez, Carter, assisted suicide