Special Section: Bioethics Beyond Borders

Physician-Assisted Death in Canada

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Abstract: The Criminal Code of Canada prohibits persons from aiding or abetting suicide and consenting to have death inflicted on them. Together, these provisions have prohibited physicians from assisting patients to die. On February 6, 2015, the Supreme Court of Canada declared void these provisions insofar as they "prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." This declaration of invalidity was scheduled to take effect one year (later extended by six months) after the ruling, to give the government time to put legislation in place. We trace the history of this decision, discuss how it has forever changed the debate on physician-assisted dying, and identify the issues that must be resolved to write the legislation. Of special importance here are the topics of access, safeguards, and conscientious objection.

Keywords: euthanasia; assisted suicide; physician-assisted death; Supreme Court of Canada; *Rodriguez v. British Columbia (Attorney General)*; *Carter v. Canada*

The Supreme Court of Canada (SCC) recently issued a ground-breaking decision on physician-assisted death (PAD) that will be read and discussed widely. The court's recognition of a constitutional right to PAD—which encompasses physicians both providing patients with the means to death (assisted suicide) and administering the lethal agent themselves (active euthanasia)—is a watershed in Canadian law and a first for a supreme court in a modern constitutional democracy. It will have a profound impact on Canadian end-of-life decisionmaking practice and is bound to be influential in debates and legal cases about PAD in other jurisdictions.

Section 14 of the Criminal Code of Canada says that "no person is entitled to consent to have death inflicted on him." Until the SCC's recent decision, this section had been read as making voluntary active euthanasia illegal. Section 241(b) of the Criminal Code says that "every one who aids or abets a person in committing suicide commits an indictable offence." In an earlier ruling, the SCC had held that this made assisted suicide illegal. Thus the debate in Canada about legalizing PAD has been over whether these sections should continue to be understood as prohibiting the practices in question. On February 6, 2015, the SCC in *Carter v. Canada*[1] settled this question by ruling that, so understood, these sections violate the Canadian Charter of Rights and Freedoms. PAD would become legal in Canada one year after the ruling. In what follows we trace the steps leading to the decision, identify how it has forever changed the shape of the PAD debate, and articulate the issues that must be faced to put this judgement into law.

History

The foundation of the *Carter* judgement was laid in 1982, when the Charter of Rights and Freedoms was added to Canada's Constitution Act.[2] This changed the

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PAD debate in two ways. First, it gave those who thought that criminal prohibition of PAD infringed constitutional rights access to the power of the courts. Second, the enumeration of the rights and freedoms provided specific categories under which those appeals could be prosecuted. The most relevant sections are as follows:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. . . .
> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. . . .
> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefits of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Eleven years later the first Charter challenge to the laws prohibiting PAD took place. Sue Rodriguez was a 42-year-old woman suffering from amyotrophic lateral sclerosis (ALS) who sought to have a qualified physician assist her in terminating her life at the time of her choosing. In *Rodriguez v. British Columbia*[3] she petitioned to have section 241(b) declared invalid under sections 7, 12, and 15 of the Charter. Section 12 prohibits "cruel and unusual treatment," but this appeal found no support in the court and does not figure in the subsequent PAD debate, and we set it aside.

In a 5–4 decision, Sue Rodriguez lost her case. The majority rejected the claim that the laws in question represented a violation of Charter-protected rights. Section 7 liberty rights were infringed insofar as disabled persons could not lawfully do what others could—namely, commit suicide—and security rights were infringed because those individuals would then have to endure a dreadful death. Nonetheless, these infringements were "in accordance with principles of fundamental justice" because (so the argument went) a ban on PAD protects the vulnerable from abuse or misuse, and so its prohibition is not "arbitrary or unfair." Thus, considered overall, no section 7 right is violated by section 241(b). The further question regarding whether this section's restrictions on personal liberty and security in choosing PAD could be (as section 1 has it) "demonstrably justified in a free and democratic society" thus did not have to be addressed. The majority did not speak to the merits of the section 15 challenge but argued that, even assuming it was successful, the violation of the equality guarantee would be saved under section 1 as a demonstrably justified restriction of Charter rights. In the minority, two justices (one of whom is now the chief justice and the only member remaining from the *Rodriguez* court) thought section 241(b) violated the liberty and security clauses of section 7. One held that it violated the equality guarantee of section 15 in that it discriminated against the disabled, and one held that it violated both sections 7 and 15. None of the minority thought that these violations could be saved under section 1.

For 20 years this put to bed legal challenges to the Criminal Code, but not the debate, and two significant government reports were issued. The first was "The Special Senate Committee on Euthanasia and Assisted Suicide" (1995). Like *Rodriguez*, this report split on the issues. The majority recommended that assisted

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suicide remain illegal, with a minority recommending that it be allowed under carefully defined circumstances. The majority similarly recommended that both voluntary and nonvoluntary euthanasia should remain criminal offenses but recommended a lesser penalty when the motivation is mercy or compassion. A minority wanted to permit voluntary euthanasia for competent individuals who are physically incapable of participating in assisted suicide.

The Royal Society of Canada in 2011 issued a unified and bolder report, "End-of-Life Decision Making," which to a notable extent presaged the *Carter* judgement. It argued that there is no morally relevant difference between assisted suicide and voluntary euthanasia and that both must be available under a broad range of circumstances. It also went beyond the recent SCC judgement (as we will see) by recommending that PAD should be made available to mature minors and through advance directives.

Following these reports, on June 10, 2014, the first right-to-die legislation in Canada was passed when the province of Quebec's national assembly passed Bill 52 ("an Act respecting end-of-life care").[4] In Canada, healthcare falls under provincial or territorial jurisdiction, and hence—so the Quebec politicians argued—Quebec was free to pass such an act. To be eligible for PAD under this act patients must

> (1) be an insured person within the meaning of the Health Insurance Act; (2) be of full age and capable of giving consent to care; (3) be at the end of life; (4) suffer from a serious and incurable illness; (5) be in an advanced state of irreversible decline in capability; and (6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

The act also specifies that the request to die must be repeated; made on an official form; and signed, witnessed, and countersigned, and that a second physician must certify in writing that the preceding conditions are satisfied. The act came into force on December 10, 2015.

Then, in February 2015, came the landmark *Carter* case. The court unanimously found that the prohibition of PAD infringes the liberty and security rights of section 7. To these findings it added that the prohibition infringes the right to life as well, because the prohibition of PAD has the effect of forcing some individuals to take their own lives prematurely—that is, before they become incapacitated from their illness. The key question thus came down to whether the blanket prohibition of PAD was necessary to protect the vulnerable. This is the claim that defeated Sue Rodriguez and has been the traditional stumbling block to PAD, but the SCC swept it aside. In doing this the court relied on the comprehensive discussion of risks and safeguards—arguably the most thorough treatment of the topic available—presented in the British Columbia Supreme Court (BCSC),[5] from which the case originated. This discussion contended that evidence accumulated from permissive regimes since the *Rodriguez* decision does not show any risk to the vulnerable from misuse or abuse, or a slippery slope, that would require an absolute prohibition of PAD.

On these grounds the court ruled, 9–0, that the sections of the Criminal Code prohibiting PAD are unconstitutional. Specifically, it found that legislation cannot prohibit PAD for competent adults who (1) clearly consent to the termination of

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life and (2) have a grievous medical condition (including an illness, disease, or disability) that is irremediable (meaning that it cannot be alleviated by means acceptable to the individual) and causes enduring suffering that is intolerable to the individual. The court gave Parliament 12 months (later extended by 6 months) to enact legislation in accordance with this decision. It was a remarkable performance by the court, notable both for the breadth of access it allows and the fact that the author or authors who wrote the judgement are not identified. It reflects the special depth of the court's accord that no author is attributed, a clear gesture that its reasoning be read to cut cleanly across the so-called liberal and conservative voices on the court.

Changes to the PAD Debate

This case has permanently changed the shape of the PAD debate both in and outside of Canada. In all future debates it will be impossible to ignore the SCC's assessment of risk, and hard to reverse it. Once PAD cannot be blocked by appeal to risk to others, however, the only way to set PAD aside is to appeal to either religious grounds or its intrinsic wrongness, and both appeals are fraught with difficulty. Religious considerations cannot be the basis of law in any country that recognizes the separation of church and state. It is also problematic that the entire case against PAD can be borne by the claim that PAD is intrinsically wrong. That claim rests on the moral relevance of the killing/letting die distinction, and that is not supported by convincing argumentation or (as, the SCC reports, the BCSC finding) the majority of ethicists (para. 23). Prohibiting PAD has thus become much harder.

The SCC case also adds two new pro-PAD arguments to the standard repertoire. The first (originating in *Rodriguez*) is that prohibiting PAD discriminates against the disabled in that it treats those who are not physically able to end their lives from doing what able-bodied people legally can. The second is a pro-life argument and contends that individuals who now regard their lives as worth living and can end them without help may be driven to end them prematurely for fear that their lives will become intolerable and they will be unable to act. Thus the prohibition of PAD in order to preserve life jeopardizes life. Rather than appealing to suffering, autonomy, and dignity as do the traditional arguments, these arguments appeal to inconsistency. And, because consistency is a matter of logic, cases built on it tend to be more convincing than those built on the standard stuff of values. It is unusual in a controversy of such long standing as PAD to have fresh arguments appear. It is even more unusual for them to come to moral philosophy from lawyers.

The Future

In *Carter* the SCC suspended the effect of its declaration for 18 months to give governments time to put legislation in place, and we now turn to the question of what the legislative options are. PAD involves questions of criminal law (a federal matter) and health law (a provincial/territorial matter), and one option open to both governments is to ignore the SCC ruling. Canada is a parliamentary democracy where the ultimate authority rests with Parliament and not the courts. Section 33 of the Charter allows that an act of Parliament or the legislature may operate regardless of whether it conflicts with section 2 or sections 7–15 of the Charter as

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long as the governments in question expressly acknowledge the conflict. This clause has rarely been used, however, and because polls have consistently shown that a large majority of Canadians in every region and age group support PAD,[6] no one expects that it will be in this case.

More realistically, the federal government could acknowledge the reduced scope of the sections of the Criminal Code in question. The unanswered question is whether the federal government, which strongly fought *Carter*, will attempt to narrow or impede the ruling's application. But it could also recognize the limits of the Criminal Code and leave the matter of what to do about PAD to the provinces and territories. That, in turn, may lead to inconsistent implementation. This would be similar to what happened when the SCC in 1988 struck down the laws criminalizing abortion[7] and the federal government failed to rewrite the legislation. The result was that abortion was (and is) not uniformly available to women in Canada. Not all hospitals perform abortions, and not all provinces/territories provide sufficient funding to make them readily available. There is thus an inequality of access that it would be undesirable to see duplicated in PAD.

To work out national regulations, three main issues must be decided. The first and most fundamental is that of patient access. In *Carter* the SCC ruled that any competent adult who has a grievous condition, experiences suffering that is irremediable in any way acceptable to the person, and makes a voluntary and informed choice is entitled to PAD. This is the minimum access to PAD that is constitutionally required. Some of the model legislation now emerging embraces this view. On the other hand, the SCC emphasized that it made no ruling on other situations in which PAD may be sought (para. 127), and provinces/territories are thus free to make access wider. There is also reason to do so. The SCC ruling excludes from PAD minors (mature and otherwise), adults who are not now competent (and perhaps never have been), and competent individuals who want to make provision for PAD by an advance directive. The equality arguments used in *Carter* apply equally to these. Life-sustaining treatment can be withheld or withdrawn from all these people on their authority or that of their substitute decisionmaker. They thus can have relief from an intolerable condition, whereas patients whose lives are not dependent on treatment but who are otherwise in the same position cannot. Accordingly, the same arguments that brought us to the *Carter* decision can take us beyond it. It would also appear inconsistent with *Carter* not to take that step. If there is no morally relevant difference between withholding or withdrawing life-sustaining treatment and PAD, and if PAD poses no additional risks, it should be available in all the circumstances in which life-sustaining treatment can be withheld or withdrawn.

The second question concerns safeguards. One way of proceeding is to require that before PAD can be provided certain conditions—such as a second opinion, a mandatory waiting period, repeated requests, witnessing procedures, and so on—must be satisfied. This is the approach taken by Quebec's act, and by all the jurisdictions in the world that allow PAD. It also receives some encouragement from the research presented in the BCSC, which concludes that the risks inherent in PAD can be very substantially minimized through a "carefully designed system imposing stringent limits that are scrupulously monitored and enforced" (para. 883; cited in *Carter* at para. 105). There is, however, a second approach possible. Under Canadian law, withholding or withdrawing treatment is governed primarily by laws that regulate consent to treatment and by decisions like the *Nancy B v. Hotel-Dieu*

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de Quebec decision, which acknowledges a right to have treatment withdrawn or withheld, including a right to require healthcare providers to withdraw treatment if the patient is unable to do this for him- or herself.[8] What decision is made is left as a private matter unregulated by special safeguards among physicians, patients, and families. PAD could be treated in the same way, and the SCC encourages this when it comments that no greater risks attend PAD (para. 115).

The third question is that of conscientious objection. In *Carter* the SCC noted that its decision did not compel individual physicians to provide PAD and left it in the hands of the physicians' colleges, Parliament, and legislatures to provide access to PAD in a way that reconciled patients' and physicians' Charter-protected rights (para. 132). The general question of conscientious objection, then, must be addressed and comes in two versions. The first concerns physicians or healthcare providers who are asked to participate in PAD. It is generally acknowledged that physicians and allied healthcare professionals such as pharmacists (who figure particularly prominently in PAD) should not have to provide PAD when they conscientiously object to it. The question is whether they have to refer patients to others who will provide the service. On the one hand, PAD could be treated just like abortion, for which the Canadian Medical Association requires physicians to make a referral. This view has its supporters, but it is faced with the problem that if one conscientiously objects to providing or facilitating PAD oneself, one typically will conscientiously object to referring a patient to another who will do these things. Accordingly, legislatures may take the view that respect for conscience (the freedom of which is a fundamental freedom guaranteed by section 2 of the Charter) cannot require physicians or healthcare providers to make a referral. An alternative is for the physician or healthcare providers to inform the hospital (or pharmacy or other relevant professional body) that they are conscientiously objecting to doing something that is permitted or mandated by a professional standard. It would then be up to the hospital, profession, and so on, to find someone who can in a timely way step in and address the request.

The second question of conscientious objection concerns whether institutions that have religious or other objections to PAD must facilitate the provision of the practice. There are likewise two sides to this question. One view is that if they accept public funds they must. But it is not clear that the public funding argument works on its own, because physicians and pharmacists in Canada also receive public payment for their services. On the contrary, one may argue that, just as physicians and pharmacists can discharge their obligation to care for patients by having them referred to others, an institution can do the same by arranging to have the patient transferred to another hospital. On the other hand, hospitals are considerably scarcer than physicians and healthcare providers, and transferring a patient to another institution for PAD is more disruptive and burdensome to the patient than simply transferring care to another physician, to say nothing of encouraging the air of an execution. Thus it is not clear whether patients will have reasonable access to PAD (including free and informed decisionmaking), continuity of care, and freedom from potential stigmatization unless all hospitals, hospices, and so on, that serve the public provide PAD. There is thus an argument that patients' rights will only be respected by requiring all public providers of healthcare to make provision for PAD.

To have uniform national regulations on PAD, the legislatures must agree on these issues. Given the complexity and potential divisiveness of these issues,

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decisionmakers may not be able to reach agreement on everything, but agreement on a common core may emerge. Legislatures may agree, for example, that every public hospital must offer PAD and give all patients ready access to it but may differ on how permissively it is offered and whether to have special safeguards in place. Thus the provinces/territories may be faced with a choice between having (minimally or radically) different legislation and compromising on what they ideally want in order to achieve uniformity. Different legislation on matters of health would not be a novelty in Canada, which already has 12 different mental health acts and 11 versions of advance directive legislation, and this situation in PAD may be better than adopting legislation that finds the lowest common denominator but that is otherwise objectionable to some or all.

In 1983 the Law Reform Commission of Canada, after recommending that no change be made to the law relating to PAD, wrote: "A country like Canada could not, without violating its social conditions and history, tolerate and give a legal veneer to a policy of active euthanasia, not even voluntary euthanasia."[9] We still have a way to go, but we have come an even longer way.

Notes

1. *Carter v. Canada (Attorney General)*, 2015 SCC5.
2. Canadian Charter of Rights and Freedoms, part I of the Constitution Act, 1982.
3. *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.
4. Act Respecting End-of-Life Care, CQLR, c. S-32.0001.
5. *Carter v. Canada (Attorney General)*, 2012 BCSC 886.
6. Majority of Canadians approve of assisted suicide: poll. *Globe and Mail* 2013 Oct 11; available at http://www.theglobeandmail.com/news/national/majority-of-canadians-approve-of-assisted-suicide-poll/article14819642/ (last accessed 11 Apr 2016). Doctor-assisted suicide supported by majority of Canadians in new poll. *CBC News* 2014 Oct 8; available at http://www.cbc.ca/news/health/doctor-assisted-suicide-supported-by-majority-of-canadians-in-new-poll-1.2792762 (last accessed 11 Apr 2016).
7. *Regina v. Morgentaler*, [1988] 1 S.C.R 30.
8. *Nancy B v. Hotel-Dieu de Quebec* (1992), 86 D.L.R. (4th) 385.
9. Law Reform Commission of Canada. *Euthanasia, Aiding Suicide and Cessation of Treatment* [final report]; 1983, at 19.

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