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The Right to Die: Legalizing Medical Assistance in Dying in Canada

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Abstract

Permitting medical assistance in dying has been a contentiously debated issue in Canada for decades. In June of 2016, the federal government passed legislation that amended the *Criminal Code* to permit eligible adults to request and receive medical assistance in dying (MAiD). Two major Supreme Court cases challenged the prohibition of MAiD, with very different results. Although the cases of *Rodriguez v. British Columbia* and *Carter v. Canada* were strikingly similar, a shifting political, social, and international landscape over the two decades between the two cases produced very different outcomes. The 2015 landmark decision in *Carter v. Canada* thrust the issue of MAiD onto the federal government's agenda. While federal legislation was enacted, the provision of MAiD falls to the responsibility of provinces and territories. Ensuring that the practice is properly implemented, monitored, and regulated will be a pressing challenge moving forward.

L'autorisation de la pratique de l'aide médicale à mourir est une question controversée au Canada depuis plusieurs décennies. En juin 2016, le gouvernement du Canada a adopté des mesures modifiant le Code Criminel afin de permettre aux adultes éligibles de recevoir l'aide médicale à mourir (AMM). Deux cas portés devant la Cour suprême du Canada ont contesté la prohibition de l'AMM avec des résultats très différents. En dépit de la similitude des cas de Rodriguez contre la Colombie Britannique et de Carter contre le Canada, les transformations politiques et sociales au cours des 20 dernières années, tant au Canada qu'à l'international ont conduit à des résultats très différents. Le tournant marqué en 2015 par la décision rendue dans Carter contre le Canada a placé la question de l'AMM très haut dans la liste des priorités du gouvernement fédéral. Cependant, même si la loi a été définie au niveau fédéral, la mise en oeuvre de l'AMM demeure la responsabilité des provinces et territoires. Assurer que la pratique de l'AMM soit bien encadrée, suivie, et règlementée représentera un énorme défi.

Key Messages

- The new federal legislation legalizes the provision of medical assistance in dying and establishes a regulatory framework for implementation, providing individuals with greater autonomy and choice in end-of-life decisions.
- Medical assistance in dying sits at the intersection of criminal law (federal) and health care provision (provincial/territorial) thus mobilizing responsibilities at all government levels.
- While implementation of medical assistance in dying has moved forward, precise mechanisms for establishing monitoring systems and documentation remain unclear.

Messages-clé

- *La nouvelle loi fédérale autorise l'utilisation de l'aide médicale à mourir et établit des règlements encadrant son application, offrant ainsi une meilleure autonomie et plus de choix quant aux décisions de fin de vie.*
- *L'aide médicale à mourir se trouve à l'intersection de la loi criminelle (fédérale) et du domaine de la santé (provincial/territorial) et nécessite la mobilisation des politiques à tous les niveaux de gouvernement.*
- *Malgré des progrès dans la mise en oeuvre de l'aide médicale à mourir, il reste toujours à mettre en place des mécanismes précis sur des systèmes de suivi et de documentation clairs.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 17 June 2016, the federal government passed Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. The principal aim of the law was to legalize the provision of medical assistance in dying (MAiD) defined as: (a) the administration of a substance that results in an individual's death; or, (b) prescribing or providing an individual with the means to end their life. A designated medical professional, at the request of the individual, must carry out administration or aid. *The Criminal Code* (1985) was amended to add two primary exemptions to s.14 and s.241(b). The new law also outlined a regulatory framework for the eligibility criteria in accessing MAiD and a number of safeguards to protect vulnerable individuals from abuse or error.

The terminology used in the discussion of MAiD in Canada has evolved over time. Early discussions revolved mainly around “physician-assisted suicide” or “voluntary euthanasia”: the former being when a medical practitioner provides *assistance* in obtaining or administering treatment that intentionally causes death; and, the latter, whereby the *act of administering* the treatment that intentionally causes death is done by the practitioner (Butler and Tiedemann 2015). The term “physician-assisted death” (PAD) was eventually used to encompass both assisted suicide and voluntary euthanasia. This ultimately changed to MAiD, acknowledging that many medical professionals (not just physicians) would be involved.

2 HISTORY AND CONTEXT

2.1 *The Criminal Code*

While attempted suicide was decriminalized in 1972, the provision of MAiD was, until recently, illegal due to two sections of the *Criminal Code* (1985):

- s.14, where no person can consent to have death inflicted on them, and that consent does not remove the criminal responsibility of anyone who inflicts death on that individual; and,
- s.241, where anyone who (a) counsels [or abets] a person to die by suicide; or, (b) aids a person to die by suicide is indictable of a criminal offence.

2.2 *The Canadian Charter of Rights and Freedoms*

The Charter of Rights and Freedoms (the *Charter*) has also been central to the discussion of PAD (*Canadian Charter* 1982). If a law is found to infringe on Charter rights and freedoms, it can be declared to be of “no force and effect”; thus, providing a means by which individuals can challenge government legislation or action (Special Senate Committee on Euthanasia

and Assisted Suicide 1995). An important caveat is that no Charter right is considered to be absolute. Under s.1, if a law is found to infringe on a Charter right, in order to be considered unconstitutional it must also be considered an unreasonable limitation on the ability to exercise that right (*Canadian Charter* 1982).

2.3 Challenging the ban on physician-assisted dying

One of the most notable attempts to overturn the ban on physician-assisted suicide in Canada was on behalf of Sue Rodriguez. In 1992, Ms. Rodriguez, who suffered from amyotrophic lateral sclerosis (ALS), challenged the prohibition on assisted suicide put forward in s.241(b) of the Criminal Code, arguing that the ban infringed on the s.7 right to “life, liberty, and security” (Smith 1993). Furthermore, because attempted suicide was decriminalized in 1972, prohibiting assisted suicide infringed on the s.15 Charter right that dictates equality before and under the law and “equal benefit of the law without discrimination” (*Canadian Charter* 1982). By the time Ms. Rodriguez’s condition would progress to a point that life would no longer be bearable, the physical capacity to take her own life would be gone (Smith 1993).

In the case of *Rodriguez v. British Columbia*, both the Supreme Court of British Columbia (BCSC) and the BC Court of Appeals ultimately rejected the request to be granted the right to assisted suicide. The case was taken to the Supreme Court of Canada (SCC), which on 30 September 1993 ruled against Rodriguez in a narrow 5-4 decision (Smith 1993). In the question of whether the violation of s.7 through the ban on assisted suicide was justified, the majority argument found that the state has a “fundamental interest in protecting human life. . . [and] in order to protect the lives of the vulnerable, it is necessary to maintain a blanket prohibition on assisted suicide” (Smith 1993). Insofar as s.241(b) of the *Criminal Code* violated Ms. Rodriguez’s rights under s.15 of the Charter, the majority argued that the infringement was justified under s.1 and that the limits imposed by the law were reasonable in protecting vulnerable individuals from abuse and preventing a “slippery slope” towards involuntary euthanasia (Smith 1993). Contrastingly, a minority judgement argued that the blanket prohibition of assisted suicide was too severe to be justified under s.1 of the Charter. Supporting and opposing positions are summarized in Table 1.

Throughout the 1990s and 2000s, a number of federal bills were put forward to amend the Criminal Code provisions that pertained to PAD, without success (Butler *et al.* 2013). Québec (albeit contentiously) passed legislation in 2014 allowing terminally ill patients to receive medical aid in dying (Fidelman 2015). Finally, a number of jurisdictions in Europe and the United States had established legislative frameworks during the same period providing exemptions from criminal law in the case of euthanasia and/or physician-assisted suicide (Government of Canada 2016).

Table 1: Supporting and opposing positions related to MAiD

SUPPORTING	OPPOSING
<ul style="list-style-type: none"> • Greater autonomy and choice in end-of-life decision-making • Jurisdictions have permitted assisted-dying without negative consequences for vulnerable groups. • Like withdrawing or refusing treatment, MAiD could be properly situated within the continuum of end-of-life care. 	<ul style="list-style-type: none"> • Safeguards would be inadequate in preventing error or abuse; vulnerable individuals may feel pressured to end their lives. • Would result in a “slippery slope” towards involuntary euthanasia • Distracts from the need for stronger and readily available palliative care options

3 GOALS OF THE REFORM

The primary goal of the reform, as discussed in the preamble to the Act, was in “[striking] the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other” (S.C. 2016, c. 3). This goal was dictated through a number of legislative objectives that explicitly outlined “robust safeguards” to prevent abuses and errors in providing MAiD, while recognizing that competent (and eligible) adults who are suffering from a “grievous and irremediable medical condition” have the right to MAiD as an option for end-of-life care, without legal consequences for their families and the medical professionals involved (Government of Canada 2016).

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government’s agenda

The Kingdon (2003) framework on agenda setting theorizes that moving an idea higher up on the government agenda involves three primary processes: problems, proposals, and politics. When these elements come together at a critical time, this creates a “policy window” where the issue can move forward. The discussion around PAD persisted following the 1993 Rodriguez decision. Advocacy groups, civil liberties groups, and politicians advocated in support of the right to die. Numerous federal bills were put forward to legalize PAD, a number of which outlined eligibility criteria and safeguards (Butler *et al.* 2013). However, none came to legislative fruition. Instead, the “policy window” opened when the issue was thrust onto the federal government’s agenda as a result of the landmark SCC ruling in

Carter v. Canada, requiring the federal government to come to a decision within a short time frame.

4.1.1 *Carter v. Canada*

In 2011, the British Columbia Civil Liberties Association (BCCLA) launched a court challenge (similar to Rodriguez's) with the BCSC to revisit the prohibition of PAD. Decisions of the SCC are generally binding to all lower courts; however, it was argued that the Rodriguez decision did not address the issue that the current ban disproportionately affected the physically disabled (Butler *et al.* 2013). The political, ethical and social landscape surrounding the issue of PAD had been shifting in Canada and abroad. The BCSC ruled that s.241(b) of the Criminal Code violated s.7 and s.15 of the *Charter* and that these violations were not justifiable under s.1 of the Act (Butler *et al.* 2013). This ruling was appealed by the Conservative federal government and overturned by the BC Court of Appeals, which ruled that the trial judge remained bound by the earlier Rodriguez decision. The BCCLA appealed the decision to the SCC in the landmark case of *Carter v. Canada* (Butler and Tiedemann 2015). In 2015, the SCC ruled in favour of the BCSC, finding both sections of the *Criminal Code* to be void in the case that: "they prohibit [PAD] for a competent adult who (1) clearly consents to [dying]; and (2) has a grievous and irremediable medical condition. . . that causes enduring [and intolerable] suffering" (Butler and Tiedemann 2015). Unlike the Rodriguez ruling, a "blanket" prohibition of PAD was no longer considered necessary to ensure the protection of vulnerable groups. Evidence from extensive consultation as well as from international jurisdictions with established frameworks, demonstrated that effective safeguards were possible (Butler and Tiedemann 2015). Furthermore, individuals seeking these services were in danger of suffering similar abuses by not having access to MAiD and therefore resorting to ending their lives early on, while they still had the ability to do so.

4.2 The issue came onto the government's decision agenda

Governments were given 12 months (until February 2016) before s.14 and s.241(b) of the *Criminal Code* would be declared invalid in preventing eligible cases of MAiD. This deadline was eventually extended to June 2016 to give the newly elected Liberal government sufficient time to respond (Government of Canada 2016). The decision was left to the federal and provincial governments as to whether they would enact new legislation that respected the *Carter v. Canada* ruling. The concern remained that in the absence of federal legislation, the result would be a patchwork of regulations across the provinces and territories and a lack of clarity in fulfilling the SCC decision (Vogel 2015). Response from the previous Conservative government was slow. After rejecting a Liberal motion to create a special committee to develop a proposal for new legislation by summer of 2015, only in July was a three-person external panel created for consultation (Vogel 2015). Although

the federal external panel was initially established to provide options for legislation, it was eventually tasked only with summarizing the key results of its consultations (Ogilvie and Oliphant 2016). Rather, a provincial-territorial expert advisory group was established in mid-August 2015 and tasked with providing advice on the development of appropriate policies and safeguards to be put in place for the practice of MAiD (Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying 2015). Informed by an extensive consultative process, international evidence, and the work of numerous advisory committees, Bill C-14 was tabled in April 2016 and ultimately received Royal Assent on 17 June 2016 (Government of Canada 2016). A timeline of key events is shown in Figure 1.

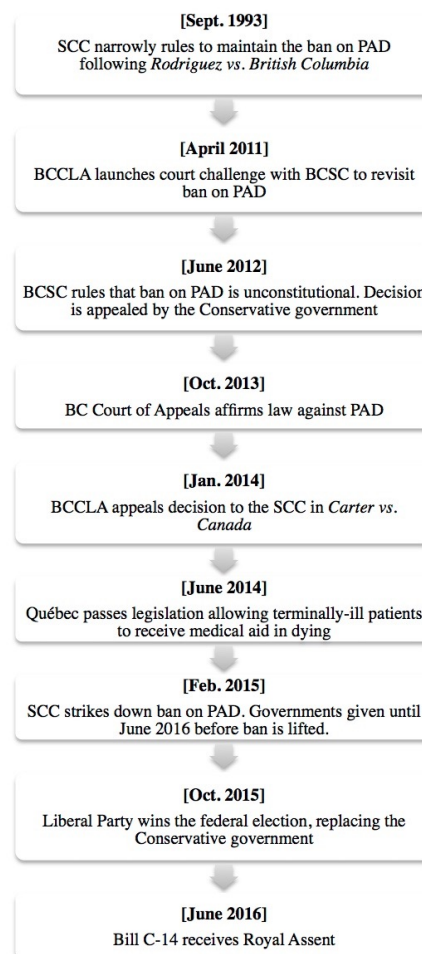


Figure 1: Key events related to the introduction of MAiD in Canada

5 HOW THE REFORM WAS ACHIEVED

The reform was achieved through regulatory legislation that dictated amendments to the *Criminal Code* and related Acts to allow for appropriate exemptions in the case of MAiD. The federal legislation expanded upon the SCC decision and outlined eligibility for the legal provision of MAiD as well as various safeguards to avoid abuse and error. Bill C-14 defined the exemptions from relevant sections of the *Criminal Code* in the provision of MAiD and established a regulatory framework for eligibility and appropriate safeguards (S.C. 2016, c.3). However, given that the practice of MAiD is rooted in health care, implementation falls largely to the purview of provinces. As a result, this may threaten the ability to ensure the provision of comparable services across Canada by creating a patchwork of policies and practices (Health Canada 2017). Another important concern related to legalizing the practice of MAiD was that it would threaten the availability, quality, and improvement of palliative care. In the recently negotiated Health Accords, considerable emphasis was placed on funding directed towards improvement of home care, including palliative care (Stanbrook 2016). Furthermore, Bill C-277 *An Act Providing for the Development of a Framework on Palliative Care in Canada* was tabled in December 2015, calling for the development and implementation of a national palliative care framework (Bill C-277 2015).

6 EVALUATION

The reform has not been in place long enough for a formal evaluation to be undertaken, but monitoring of the practice of MAiD will be essential. The new legislation explicitly discusses the need for a pan-Canadian system to collect data, monitor trends, and deliver information on implementation of MAiD to the public (Government of Canada 2016). Furthermore, the law requires the federal Minister of Health to put any necessary regulations in place to establish systems for monitoring requests for and provision of MAiD (Government of Canada 2016). This process was initiated in the fall of 2016 through a forum discussion hosted by the Canadian Institute for Health Information. Regulations for the establishment of the federal monitoring system are currently under development, and are expected to come into force in 2018 (Health Canada 2017). However, significant work remains to be done. Developing these systems in a timely manner will be a pressing challenge for all governments moving forward.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 2: SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ● Greater autonomy and choice for individuals in end-of-life decision-making ● Offers safeguards for protection of vulnerable groups ● Relieves burden of criminal responsibility on caregivers, family, and medical community ● Provides some regulatory framework for jurisdictions to guide implementation ● Allows health care providers to opt out based on conscientious objection 	<ul style="list-style-type: none"> ● Jurisdictional complexity as MAiD sits at the intersection of criminal law and health care thus challenging responsibilities at all government levels ● Concern that current law will exclude certain individuals from accessing services, particularly if death is not “reasonably foreseeable” as stated in the new legislation
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> ● Potential for cross-governmental collaboration in establishing monitoring systems for MAiD ● Strengthening other end-of-life-care options such as palliative care ● Commitment to further study of controversial areas such as advance directives, mature minors, and individuals with mental conditions ● More focus on end-of-life issues could lead to enhanced access to palliative care as in other jurisdictions 	<ul style="list-style-type: none"> ● While implementation has moved forward, precise mechanisms for establishing monitoring systems and documentation remain unclear. ● Ensuring consistent quality and accessibility across jurisdictions ● Development and improvement of palliative care may be jeopardized

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