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## ►► Physician-assisted dying in Canada: Where do we stand after the Supreme Court's Decision in *Carter v. Canada*?

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On February 6, 2015, the Supreme Court of Canada (SCC) released its judgment in *Carter v. Canada*, 2015 SCC 5 [*Carter*]. This much-anticipated decision changed the law relating to physician-assisted dying in Canada for individuals whose circumstances meet a list of conditions enumerated by the court, including a grievous and irremediable medical condition that causes enduring and intolerable suffering.

Assisted suicide is a highly contentious public policy issue reflected, in some small measure, by the lengthy list of intervenors in this case including religious organizations, civil rights groups and advocacy organizations of various kinds. It has been the subject of much deliberation in Canada for decades; a discussion which has played out in official reports, in private member's bills, among the medical profession and in the media, with no resolution — until now.

The SCC's decision in *Carter* adds Canada to a small but growing number of democratic jurisdictions that permit assisted dying, in one form or another. The SCC suspended the effect of its decision for 12 months to give government time to respond with new legislation. We are now more than halfway through that period and no new federal

or provincial legislation has emerged. Given that Parliament has dissolved for a federal election that will be held on October 19, it is an opportune time to reflect on the decision.

### ►► The Context

In Canada, assisted suicide is criminalized by sections 241(b) and 14 of the *Criminal Code*. Section 14 prohibits a person from consenting "to have death inflicted on him" and confirms that a person who inflicts death on another is criminally responsible, regardless of whether the person agreed to, or even asked for, death. Section 241 makes it a criminal offence to either counsel someone to commit suicide or to assist them in doing so. All legislation in Canada, including the *Criminal Code*, must comply with the *Canadian Charter of Rights and Freedoms* [the *Charter*]. Section 7 of the Charter states: "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". *Charter* rights can be infringed, but only if it is a reasonable limit prescribed by law and demonstrably justifiable in a free and democratic society (*Charter*, section 1).

*When considering whether a law is unconstitutional for violating the Charter, a court must first determine whether a Charter right has been infringed and, if so, then must assess whether that infringement is or is not justified by section 1.*

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When considering whether a law is unconstitutional for violating the *Charter*, a court must first determine whether a *Charter* right has been infringed and, if so, then must assess whether that infringement is or is not justified by section 1. In considering these two key questions, courts take a principled approach to the analysis, relying on previous decisions. If a *Charter* right has been violated, and the infringement is not saved by section 1, the law will be found to be unconstitutional. In such a case, there are a number of remedies available to the court, including, as was used in *Carter*, a declaration of invalidity. A declaration of invalidity means the law (whether an entire statute, a particular section, or even just a portion thereof) no longer has any legal effect. As in the case of *Carter*, courts often temporarily suspend declarations of invalidity, to give Parliament and/or provincial legislatures time to respond with new legislation to fill any resulting void.

Whether the *Criminal Code* prohibitions against assisted suicide unjustifiably infringe *Charter* rights was previously considered by the SCC in *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 [*Rodriguez*]. *Rodriguez* emerged out of similar circumstances to those addressed in *Carter*. Sue Rodrigue suffered from amyotrophic lateral sclerosis (ALS), a progressive and fatal degenerative disease. The initial plaintiff in *Carter*, Gloria Taylor, suffered from the same disease. In both cases, the plaintiffs argued the *Criminal Code* provisions prohibiting assisted suicide are unconstitutional because they violate the section 7 *Charter* rights to life, liberty and security of the person in a manner that is not justified by section 1 of the *Charter*.<sup>1</sup> Witnesses before the court in both cases advocated powerfully for the right to seek physician-assisted death when suffering becomes intolerable. Both cases attracted a great deal of attention and triggered complex and often highly emotional public debates. In *Rodriguez*, the SCC was divided 5-4, but the majority upheld the *Criminal Code*'s blanket prohibition against physician-assisted suicide. Twenty-two years later, the Court's conclusion was very different.

Although in general courts are required to follow the previous rulings of higher courts, settled rulings can be revisited when a new legal issue has been raised, or when circumstances or evidence have changed in way that fundamentally shifts the debate (*Canada (Attorney General) v. Bedford*, 2013 SCC 72). In *Carter*, the SCC agreed

with the trial judge that both factors were met. Since *Rodriguez*, the law surrounding section 7 of the *Charter* has developed and social and legislative facts have changed, including evidence regarding mitigation of risks from other jurisdictions that allow medical aid in dying (*Carter*, para.45).

## ►► *Carter v. Canada*

In *Carter*, a unanimous SCC found the *Criminal Code* provisions prohibiting assisted suicide (sections 241(b) and 14) are unconstitutional because they unjustifiably infringe section 7 of the *Charter*, "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" (*Carter*, para. 127). The SCC declared sections 241(b) and 14 of the *Criminal Code* of no force or effect in these circumstances, but suspended the declaration of invalidity for 12 months to give governments time to respond with new legislation. If new legislation is not in place by the end of the 12 months (February 6, 2016), physician-assisted death will be legal in cases that meet the above criteria.

Although not a case of constitutional exemption, the effect of *Carter* is essentially an exception to the criminal prohibition against assisted suicide that only applies in limited circumstances. It is only available to competent adults, not minors (i.e. children under the age of majority) or adults who lack decision-making capacity (e.g., those who are unconscious or in the later of stages of dementia). It requires clear consent, meaning involuntary euthanasia continues to be prohibited. It is limited to physician-assisted death and does not change criminal responsibility for the general public. It requires the person seeking physician-assisted death to have a "grievous and irremediable medical condition" that causes enduring and intolerable suffering. It does not however require the person to undertake treatments that he or she finds unacceptable.

The test outlined by the SCC is highly subjective; the suffering must be "intolerable to the individual in the circumstances of his or her condition" (*Carter*, para. 127). Accordingly, it is up to each person

<sup>1</sup> In both cases the plaintiffs also claimed the criminal prohibitions against physician-assisted dying violate section 15 of the *Charter*, which provides for equality rights. However, because the SCC in *Carter* concluded that section 7 was violated, it determined it was not necessary to address section 15 (*Carter*, para. 93).

to determine what is or is not tolerable, in his or her particular situation. Notably, it does not require the medical condition to be terminal, nor does it restrict availability of physician-assisted death to those with physical conditions (i.e. mental illness is not excluded), or those physically unable to end their own life without assistance.

The SCC did not set out a framework to manage the process of physician-assisted dying, noting “[c]omplex regulatory regimes are better created by Parliament than by the courts” (*Carter*, para. 125). The considerations are indeed complex. Some of the challenging operational matters left to be determined include procedural safeguards such as:

- whether more than one physician is required to sign-off;
- whether any time delay and re-affirmation of consent is required between the original request for physician-assisted death and the act;
- whether any witnesses to the request are required (and who will make an appropriate witness);
- who will evaluate and confirm that the factors laid out above (i.e. grievous and irremediable medical condition, intolerable suffering, consent, etc.) are present, in what manner and with what form of documentation;
- whether there is any minimum amount of time suffering must be present for it to be considered “enduring”;
- how will access to physician-assisted death be assured when some physicians may conscientiously object to engaging in the practice;
- whether any other healthcare professionals (e.g., nurses) can assist in the process (e.g., by administering a prescribed medication);
- whether someone can provide consent prospectively (e.g. following a diagnosis of Alzheimer’s);
- what forms of assistance will be available, and the list goes on.

Following the release of the SCC’s decision, there have been calls for legislation and/or some form of regulatory regime to fill what is viewed by some as a legal and policy gap. The need to minimize risks to vulnerable individuals while respecting the fundamental rights confirmed in *Carter* is at the heart of many of those calls.

## ▶▶ Federal vs. Provincial Leadership

The time frame for the suspension of the declaration of invalidity is more than half over, and Parliament has adjourned for the summer with no government-sponsored legislation on the order paper to address this issue. There also has been no publicly discernible hastening of the progress of existing bills on-topic including Bill S-225, *An Act to amend the Criminal Code (physician-assisted death)*, sponsored by Senator Nancy Ruth, a Conservative Senator, or Bill C-581, *An Act to amend the Criminal Code (physician-assisted*

*death)*, sponsored by MP Steven Fletcher, both of which provide for amendments to the *Criminal Code* to allow for physician-assisted death and set out associated frameworks.

National consistency in terms of procedural safeguards and access is important. Without a national strategy, variation across the country is likely. Nonetheless, while federal leadership is one option, provinces may be equally well-placed to respond, if not perhaps better. Health is a matter of shared jurisdiction between federal and provincial governments – meaning both levels of government may legislate in the area. However, previous cases (e.g., the successful constitutional challenge to the *Assisted Human Reproduction Act* – *Reference re Assisted Human Reproduction Act*, 2010 SCC 61) have demonstrated the need for the federal government to be careful not to overstep the boundaries of its authority by legislating in areas (e.g., health services provided in hospitals) falling within provincial jurisdiction. The manner in which any potential federal legislation governing physician-assisted dying is crafted would be important for its likelihood to withstand a jurisdictional challenge.

At the provincial level, Quebec has already passed legislation titled *An Act Respecting End-of-Life Care*. Although not yet in force, this Act was crafted as a comprehensive framework for end-of-life care, including both palliative care and “Medical Aid in Dying”. It establishes criteria that limits access to medical aid in dying to individuals at the end of life and, among other requirements, requires second opinions and time delays in a staged-consent process. Other provinces wishing to legislate in this area would have the option of drawing on the work Quebec has done.



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## ▶▶ What’s Next

On July 17, 2015, the federal government named a three-person panel to lead a consultation process addressing how it should respond to *Carter*. The process is promised to include consultations with Canadians and key stakeholder groups, focusing in particular on intervenors in the SCC case. The panel is due to provide its report to the Ministers of Justice and Health by the late Fall.

There is no requirement for either level of government to legislate in this area. For example, there may be useful parallels drawn with Canada's history with abortion. In *R. v. Morgentaler*, [1988] 1 SCR 30, the SCC struck down the *Criminal Code* provisions prohibiting abortion as unconstitutional and to-date, political appetite to tackle the issue directly by way of legislation remains low. Perhaps as a result of the absence of clear federal or provincial leadership in this area, there are well-recognized disparities in access to abortion across the country, particularly between rural and urban areas. There are also considerable inter-jurisdictional differences in terms of whether, and under what circumstances, the procedure is provincially funded and regarding what techniques are available. Given the equally controversial nature of physician-assisted dying and questionable level of political will to address it, the potential exists for it to develop along a similar provincial 'patchwork' fashion.

In the absence of legislation, physician-assisted suicide may be left as a matter of medical practice, essentially up to physicians and their professional self-regulatory bodies – the provincial Colleges of Physicians and Surgeons – to oversee. Indeed, regardless of whether or not legislation emerges to help shape the practice of physician-assisted dying, the Colleges will ideally have an important role to play in drafting any resulting regulatory framework and certainly in providing guidance to their members. One issue which will require the input of the Colleges is how conscientious refusals and the duty to refer will be managed, particularly given the SCC explicitly confirmed that physicians are not compelled to assist in dying (*Carter*, para. 132). These issues are already top of mind for some provincial Colleges facing related debates, for example in the context of birth control prescriptions, and will likely need to be addressed early on. As noted by the SCC, there is a need to balance the rights of patients with those of physicians, for whom deciding whether or not to participate in physician-assisted dying may engage their own *Charter* rights to

freedom of conscience and religion, as well as their professional and ethical obligations to their patients.

Other pressing questions include whether physician-assisted dying will be a funded health service under provincial plans; whether it will be like abortion, where access and associated costs vary considerably by province/territory and between urban, rural and remote areas, and whether its availability will be limited to Canadian residents, or extended to foreign nationals as well. It remains to be seen how broad the federal consultation panel's scope of enquiry will be, and what approach it will take to these and other key matters.

It is important to note that in finding the *Criminal Code's* absolute prohibition against assisted suicide was not saved by section 1 of the *Charter*, the SCC agreed "that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards" (*Carter*, para. 117). Accordingly, it seems reasonable to conclude that without a procedural framework of some kind, the balance of risks assessed by the Court could shift.

It is possible the Minister of Justice and Attorney General of Canada may seek an extension to the 12-month suspension of the declaration of invalidity. Whether that occurs will likely depend in part on which party forms the government after the election scheduled for October 19th. Another option would be for the federal government to use the notwithstanding clause, but that would be a highly controversial and fairly unprecedented approach. It will be interesting to see how much focus, if any, the issues surrounding physician-assisted dying will receive during the election campaign, and what steps the new government will take once in office. The only present certainty seems to be that the clock is ticking, and end-of-life options available in Canada to individuals suffering intolerably from grievous and irremediable medical conditions are likely to expand in the not-too-distant future.



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Amy Zarzeczny is a lawyer and health law scholar who obtained her Master of Laws with distinction from the London School of Economics and Political Science. Prior to joining the Johnson-Shoyama Graduate School of Public Policy, Zarzeczny held an Academic Trust appointment as a Research Associate at the University of Alberta's Health Law Institute. Zarzeczny has also served as Crown Counsel with the Ministry of Justice and Attorney General of Saskatchewan in the Policy, Planning and Evaluation Branch, and previously practiced law with the firm of Reynolds, Mirth, Richards & Farmer LLP in Edmonton, Alberta. Zarzeczny's research focuses on health law and health policy issues, in particular, legal, social, bioethical and policy challenges associated with different areas of emerging biotechnology and medical research. Zarzeczny also has a strong interest in health care administration and organization. She currently teaches courses in Health Law, Health Policy and Health Care Organization and Administration.

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