Check List for Legislators: Towards A Canadian Approach to End of Life Choices

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I. Introduction

Canada can do better. That is a theme found throughout the Supreme Court of Canada decision in *Carter v. Canada* [Carter).[1] In that decision, the Court ordered the Government of Canada to allow patients to make end-of-life choices that would ultimately extend life, not shorten it. The Court reasoned that patients would commit suicide earlier if they were not allowed physician assistance later. In making that order, the Court relied upon the right to life found in s. 7 of the *Charter of Rights and Freedom* (the "Charter"). The Court found that physician assistance in death was necessary in order to promote life.

II. Canada Must Protect the Vulnerable

As legislators and healthcare providers address the choice of some individuals to request physician-assisted death, it is important to keep in mind two foundational messages from the Supreme Court of Canada in *Carter*. The first is that the persons with a constitutional right to physician-assisted death are those who cannot take their own life.[2] The second is that protection for the vulnerable may not be compromised in securing the Charter right to physician-assisted death. The Court expressly excluded minors, those with a psychiatric diagnosis and those with minor medical conditions from the parameters of the decision in *Carter*.[3] This does not preclude Parliament from allowing physician-assisted suicide in such cases. However, it does suggest that Parliament should have a good reason for deviation from the standard set by the Court.

After recognizing that in some cases, the right to life required access to physician-assisted death, the Supreme Court of Canada devoted most of its reasons in *Carter* to creating a check list for legislators to reference when responding to the Court's decision to strike down s. 241(b) of the *Criminal Code*.

The Government of Canada provided to the Supreme Court of Canada compelling evidence that many jurisdictions in Europe had failed to protect the vulnerable and that patients were being killed by physicians who considered themselves above the law.[4] The failure of the European approach to physician-assisted death is highlighted by the case of Godelieva de Troyer. Last year, her son brought a claim before the European Court of Human Rights, asserting that Belgium did not adequately protect life. She had suffered a failed romance and contacted her

doctor to secure assistance in suicide. Her doctor refused, as she was suffering from mild and temporary depression. So she "doctor-shopped" until she found a physician who would kill a mildly depressed woman, and arranged her own suicide, without notice to her family or any third party.[5]

The circumstances in the case of Godelieva de Troyer would be expressly excluded from the circumstances under which a physician could offer assistance pursuant to the order of the Supreme Court of Canada in *Carter*.[6]

The Supreme Court of Canada was satisfied that Canadian legislators could create a model that is better than the one Belgium has.[7] The Court was also confident that Canadian physicians would provide appropriate leadership under a Canadian approach.[8]

III. Characteristics of a Canadian Approach

Based on the reasoning in Carter, it is clear that there are three characteristics the Supreme Court of Canada expects to see in the Canadian approach to physician-assisted death:

1. the law will be comprehensive and nuanced;

2. the law will primarily focus on protecting the vulnerable;

3. the law will be limited to those who need access to physician-assisted death in order to better enjoy their Charter right to life.

The Supreme Court of Canada did not mandate legislation. However, the Court did anticipate that Parliament and provincial legislators would cooperate to create "complex regulatory regimes ... consistent with the constitutional parameters" of *Carter*.[9] According to the Supreme Court of Canada, the protection of the vulnerable "lies at the heart" of *Carter* and was the focus of the trial judge's decision. The Court quoted with approval the conclusion of the trial judge that a "carefully designed and managed system is capable" of "protecting vulnerable people from abuse and error".[10] This is what the trial judge said:

> My review of the evidence in this section, and in the preceding section on the experience in permissive jurisdictions, leads me to conclude that the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced. [para. 883][11]

The Supreme Court of Canada was careful to limit its order regarding the right to physician-assistance in death to the following circumstances:

> Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s.7 of the Charter and are of no force or effect to the extent that 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.[12]

Under *Carter*, the Supreme Court excluded "minors or persons with psychiatric disorders or minor medical conditions" from access to physician-assisted death.[13] This view was based on two different understandings. First, Parliament is justified in protecting such vulnerable persons. Second, there are those who do not need the assistance of a physician to end their own life (for example. individuals suffering from -minor medical conditions").

IV. Stringent Limits and Other Safeguards

At the end of its reasons in *Carter*, the Supreme Court of Canada emphasized that its decision simply rendered a certain criminal prohibition invalid and that "[w]hat follows is in the hands of the physicians' colleges, Parliament and the provincial legislatures".[14]

"What follows" is the task of limiting the "risks associated with physician-assisted death through a carefully designed and monitored system of safeguards".[15]

The Supreme Court of Canada agreed with the view of the trial judge that a "carefully designed system" would include "stringent limits that are scrupulously monitored and enforced".

A. Monitoring and Enforcement

The best place to start the check list of issues to be addressed by legislators is the Carter decision itself. The primary message from the trial judge was that scrupulous monitoring and enforcement of limits on physician-assisted suicide is necessary to protect the vulnerable.

There are at least three options for policy makers facing the task of establishing monitoring and enforcement mechanisms:

1. a new Federal or provincial bureaucracy to monitor and enforce;

2. judicial oversight to monitor and enforce; and

3. an existing provincial mechanism for oversight and enforcement.

A new bureaucracy is not attractive. Healthcare and government budgets are already strained. Furthermore, the special bureaucracies established in Europe seem to facilitate, not limit, abuse.

Judicial oversight was provided by the trial process in *Carter*. It is effective, but expensive.

There is a growing consensus that the Office of the Chief Medical Examiner in the Department of Justice of each province would be an appropriate entity to provide monitoring and enforcement. In fact, many believe that the Office of the Chief Medical Examiner should also be responsible for delivering physician-assisted suicide.

If the Chief Medical Examiner is responsible for monitoring, enforcement and delivery of physician-assisted death, then each death may be reviewed prior to implementation at a time when something can be done to avoid a death that is not in compliance with the law. This is far superior to the after-the-fact monitoring and enforcement found in other jurisdictions at this time.

B. Competence and Training

Studies of jurisdictions currently allowing physician-assisted death indicate that there is typically a 25 per cent complications rate when a physician-assists in a suicide.[16] The Canadian approach need not experience negligence at such a high rate. The Chief Medical Examiner model ("CME Model") described above would allow for the adequate and focused training of specialties who would not fail at their assignments. This would save education and continuing medical education funds. It would also ensure that specialists trained in addressing death would have responsibility for physician-assisted suicide. Dabblers would have no role.

C. Accommodation of Conscience

Both Charter and human rights legislation require the accommodation of physicians objecting on grounds of conscience to physician-assisted suicide. The Supreme Court of Canada has outlined the comprehensive nature of the duty to accommodate in *Renaud v. Central Okanagan School Board*.[17]

In *Carter*, the Court was very specific about the duty to accommodate physicians in the event of a request for physician-assisted death.[18]

The likelihood of a conflict between a physician's conscience rights and a patient's choice of physician assistance in suicide would be significantly reduced under the CME Model. Only

physicians who choose to assist in death will devote the time required to be trained and certified to perform physician-assisted death.

D. Physician-Assisted Death Is Not "Core" Healthcare

The Supreme Court of Canada made it clear that physician-assisted death is not about the "core" provincial jurisdiction over health.[19]

Logically, death is the opposite of health. If physician-assisted death is not part of the "core" health system and is delivered by physicians employed by the Department of Justice, then much of the conflict faced by physicians and other healthcare providers is removed. The CME Model helps to remove conflict in a number of areas:

1. physicians and other healthcare providers will not be faced with a potential crisis of conscience when a patient chooses such an option;

2. health departments and hospitals will avoid the appearance of a conflict of interest that arises when a bed becomes available because of a patient choice of physician-assisted death;[20] and

3. palliative care physicians will not be expected to kill the patients they have sworn to save in their Hippocratic oaths.[21]

E. Public Funding

There is another reason to not classify physician-assisted death as healthcare. Public policy decisions on the funding of physician-assisted death should be made without the complication of fitting the money issue into provincial and Federal rules established pursuant to the *Canada Health Act*. Those rules are based on the concept of whether a service is medically necessary. Death is never medically necessary.

The Supreme Court of Canada has already determined in *Chaoulli v. Quebec*[22] that while there may be no Charter right to government-funded and -delivered health-related services, there is a right to secure those services from a willing seller if one's health is at stake.

It is noteworthy that The European Court of Human Rights, in *Haas v. Switzerland* [*Haas*],[23] determined that Switzerland did not have a duty to provide physician-assisted death on demand:

> In particular, the Court considers that the risks of abuse inherent in a system that facilitates access to assisted suicide should not be underestimated. Like the Government, it is of the opinion that the restriction on access to sodium pentobarbital is designed to protect public health and safety and to prevent crime. In this respect, it shares the view of the Federal Court that the right to life guaranteed by Article 2 of the Convention obliges States to establish a procedure capable of ensuing that a decision to end one's life does indeed correspond to the free will of the individual concerned. It considers that the requirement for a medical prescription, issued on the basis of a full psychiatric assessment, is a means enabling this obligation to be met. Moreover, this solution corresponds to the spirit of the United Nations Convention on Psychotropic Substances and the conventions adopted by certain member States of the Council of Europe.[24]

F. Voluntary and Informed

The Supreme Court of Canada has given a number of directions regarding the information that must be collected and made available to the patient prior to decision making on the subject of physician-assisted death.

First, the decision must be voluntary. The patient must "seek assistance in dying", and it must not be the physician offering suicide.[25]

Second, a full diagnosis must be identified. The diagnosis must address all of the issues identified by the Supreme Court of Canada as relevant:

1. Is there a psychiatric disorder?

2. Is there a grievous and irremediable medical condition that causes enduing suffering intolerable to the patient in the circumstances?

3. What is the prognosis?

4. What are the full range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding loss of personal dignity?[26]

The potential for abuse in the absence of consent is well illustrated by what happened to the mentally disabled in Alberta between 1929 and 1972.[27]

G. Mature Minors are Vulnerable

The Supreme Court of Canada determined in *Carter* that minors (those under the age of 18) were a vulnerable class and should not be faced with making life-and-death decisions.[28] This is rational and consistent with Canadian public policy evident in other parts of the *Criminal Code*.

Individuals under the age of 18 may not consent to sexual exploitation, even if they are mature minors capable of understanding the nature and consequences of their actions. Those under the age of 18 may not consent to human trafficking, pornography or prostitution.[29] Parliament may take same direction from the Supreme Court of Canada in A.C. v. Manitoba.[30] In that case, the Court made three points:

1. Parliament should act in the best interests of children;

2. It is in the best interest of children that there be a presumption that those under 18 cannot give an informed consent to death;

3. There may be cases where a child may overcome the presumption of lack of capacity to death.[31]

H. Other Situations and Other Healthcare Providers Subject to the *Criminal Code*

The Supreme Court of Canada made no pronouncement on "other situations" where physician-assisted dying may be sought.[32] The Court left it up to Parliament to create the "complex regulatory regime" necessary to address all aspects of the issue.

Three of the most important questions that remain after *Carter* are as follows:

1. May physicians be charged with the violation of other sections of the *Criminal Code* if they administer a lethal injection?

2. May other healthcare professionals be charged under the *Criminal Code* if they assist the physician in assisting the patient in death?

3. May the health facility in which patients are resident safely allow a physician to assist in death in the health facility?

Section 241(b) of the *Criminal Code* is not the only section implicated by, or potentially applicable to physician-assisted death. In 1995, the Special Senate Committee on Euthanasia and Assisted Suicide identified the following sections of the *Criminal Code* as requiring the attention of Parliament if physician-assisted death is to be legalized:

14. Consent to Death;

216. Duty of Persons Undertaking Acts Dangerous to Life;

217. Duty of Persons Undertaking Acts;

219. Criminal Negligence;

220. Causing Death by Criminal Negligence;

229. Culpable Homicide (Murder);

241. Counselling or Aiding Suicide;

245. Administering Noxious Thing;

265. Assault;

267. Assault Causing Bodily Harm;

268. Aggravated Assault; and

269. Unlawfully Causing Bodily Harm.

In the process of amending the *Criminal Code* provisions identified above, Parliament should ensure that all healthcare providers and facilities are protected from criminal charges in the event of a properly administered physician-assisted death.

I. Civil Liability

There is a significant role for each province in determining the civil consequences of a physician-assisted death. The trial judge in *Carter v. Canada* addressed some of them at paras. 1413 and 1414.[33] In the absence of provincial legislative action, there is potential for chaos and needless litigation.

The primary questions of liability and public record in a province include the following:

1. How will the death be recorded (as suicide or the result of the underlying diagnosis)?

2. How will life and health insurance providers he required to respond (may they treat physician- assisted death as suicide)?

3. May family members who were dependant on a patient who chooses physician-assisted death maintain a claim for wrongful death against those who assisted?

The consequences of failure to act to limit liability will in all likelihood result in litigation for wrongful death. While large judgments are typically restricted to south of the U.S.-Canada border,[34] there are suicide-related judgments against hospitals from time to time in Canada.[35]

J. Notice

The question of privacy is particularly sensitive. Families naturally desire privacy at the time life ends. However, the public has an interest in knowing when the life of a citizen has been taken with the approval of the state. Secrecy can lead to abuse.[36]

A useful analogy may be made to the guardianship process for those who have become mentally incompetent. Provincial law typically requires notice to the next of kin when an application for guardianship is commenced. The same list would have an interest in the planned death of a family member. The CME Model could help facilitate such notice.

Provincial legislation in this area would avoid sonic of the conflict that has arisen in Europe when physicians have killed their patients in secret and failed to report such killings to the public authorities, as required by law.

K. Grievous and Irremediable Medical Condition

There are two questions that must be answered by Parliament in connection with the concept of a "grievous and irremediable medical condition" adopted by the Supreme Court of Canada in *Carter*.

First, will that test be adopted by Parliament as the basis for allowing access to physician-assisted death?

Second, will Parliament further define the concept to expand or restrict the group that may choose physician-assisted death?

L. Residency

Parliament or legislatures may desire to address the public policy issues that surround "death tourism". There may be good reasons to permit or to deny non-residents access to physician-assisted death in Canada. The debate on this subject may be significantly impacted by the decision of a provincial government on the question of whether the public will pay for physician-assisted death.

M. Process

Parliament and provincial legislatures will want to consider important issues of due process, including the following:

1. Will healthcare providers be prohibited from raising the subject with a patient without the patient first asking for physician-assisted death?

2. Will there be a requirement for a written, audio or video record of the "informed consent"?

3. Will there be a minimum cooling off period?

4. Will the written opinions of two or more physicians be required?

5. Will a minimum number of witnesses be required to confirm consent or observe death?

6. Will a video and audio recording of the death be mandated?

7. Will there be limits on who may administer a lethal injection (the physician, a non-physician or the patient)?

8. Will a review panel be established to provide post death review?

9. Will an appeal panel be established to allow pre-death review at the request of a family member?

10. Will an appeal panel be established to allow pre death review at the request of a family member?

N. Advance Directives

Advance directives consenting to euthanasia would not be consistent with the reasoning set forth in *Carter* and *Re Eve*.[37] In other words, directions regarding death may not be given in advance. Existing Supreme Court of Canada authorities support the proposition that at the time of death there must be a continuing consent to physician-assisted death maintained by a competent adult.[38]

Parliament may choose to legislate otherwise. However, in the absence of amending legislation, physicians who rely upon advance directives for consent will risk charges of homicide under the *Criminal Code*.

V. Conclusion

The trial judge and every judge of the Supreme Court of Canada in *Carter* expect a great amount from Parliament and provincial legislatures. The judges took a look around the world and saw that a number of countries were failing at end-of-life care and assistance in death. However, they were not dissuaded from their opinion that Canada could do better. They were satisfied that a *Made in Canada* approach to physician-assisted death would

1. respect the Rule of Law;
2. protect and promote life at every stage;
3. protect the vulnerable from abuse and death;
4. avoid the loss of personal dignity;
5. ensure patients considering physician-assisted death are fully informed;
6. accommodate the conscience and medical opinions of every physician;
7. facilitate access to a physician who desired to provide assistance in death;
8. include safeguards that are monitored and enforced.

The Canadian approach will be balanced.[39] A system with no safeguards will be as open to challenge under s. 7 of the Charter as the current total prohibition model.[40]

Once a new complex and nuanced system is in place, the Supreme Court of Canada will give it a high degree of deference.[41]

Parliament may impose on physician-assisted death every limit that it believes necessary to protect the vulnerable, and the Supreme Court of Canada has signalled that Parliament's decision on safeguards will likely pass muster if challenged. This should encourage Parliament to take the time and put in the effort to answer the questions healthcare providers are asking about *Carter*. They deserve a legislative answer.

[*Editor's note*: Gerald Chipeur, QC, is a partner with Miller Thomson LLP, who, over the last three decades, has acted as an appellate and trial lawyer and also helped public and private sector clients navigate the rules regulating businesses and governments. He is a contributing editor of the *Charter and Human Rights Litigation Quarterly* and was counsel to one of the interveners in *Carter v. Canada*. Most recently, the author was the 62nd and final witness to testify before the Special Joint Committee of the Senate and House of Commons on Physician-Assisted Dying.]

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1 [2015] S.C.J. No. 5, 2015 SCC 5.

2 *Ibid*., para. 90.

3 *Ibid*., para. 111.

4 *Ibid*., paras. 110-113.

5 European Court of Human Rights application form filed by Tom Mortier, dated August 18, 2014.

6 *Supra* note 1, para. 111.

7 *Ibid*., paras. 113 and 117.

8 *Ibid*., para. 116.

9 *Ibid*., paras. 98, 125, 126 and 132.

10 *Ibid.,* para. 105.

11 *Ibid*.

12 *Ibid*., para. 147.

13 *Ibid*., para. 111.

14 *Ibid*., para. 132.

15 *Ibid*., para 117.

16 Johanna H. Groenwoud *et al.*, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands" (February 24, 2000) 342 *New England Journal of Medicine* at 551, 554-555.

17 [1992] S.C.J. No. 75, [1992] 2 S.C.R. 970.

18 *Supra* note 1, para. 132.

19 Ibid., para. 53.

20 *Rasouli v. Sunnybrook Health Sciences Centre et al.*, [2011] O.J. No. 2984, 2011 ONCA 482, affirming [2011] O.J. No. 1100, 2011 ONSC 1500.

21 *D'Amico v. Quebec*, Quebec Superior Court, December 1, 2015 (500-17-082567-143).

22 [2005] S.C.J. No. 33, 2005 SCC 35, [2005] 1 S.C.R. 791, paras. 102-124.

23 European Court of Human Rights, Application No. 31322/07 (January 20, 2011).

24 *Ibid*., para. 58.

25 *Supra* note 1, para. 106.

26 *Ibid*., para. 106.

27 J. Grekul, H. Krahn and D. Odynak, "Sterilizing the 'Feeble-minded': Eugenics in Alberta, Canada, 1929-1972" (December 2004) 17 *Journal of Historical Sociology* 4.

28 *Ibid*., para. 111.

29 *Criminal Code*, RSC 1985, c C-46, ss. 163.1, 279.011, 286.3 and 286.3.

30 [2009] S.C.J. No. 30, 2009 SCC 30.

31 *Ibid*.

32 *Supra* note 1, para. 127.

33 [2012] B.C.J. No. 1196, 2012 BCSC 886.

[34] For example, see *Rio Grande Regional Hospital Inc. v. Villrreal* (329 S.W. 3d 594, 2010 Tex. App. LEXIS 7990 2013 Tex. LEXIS 725) in which a $9 million judgment was granted to the family of a patient who committed suicide in a hospital with a razor given to him by a nurse.

[35] For example, see *DeJong (Litigation guardian of) v. Owen Sound General*, [1996] O.J. No. 809.

[36] *Supra* note 22, para. 57.

[37] [1986] S.C.J. No. 60, [1986] 2 S.C.R 388.

[38] *Supra* note 1, para. 147.

[39] *Ibid*., para. 98.

[40] *Supra* note 22, paras. 56-58.

[41] *Supra* note 1, paras. 97-98; supra note 22, para. 55.