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Euthanasia and Assisted Suicide in Canada

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(Background Paper)

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CONTENTS

1	INTRODUCTION.....	1
2	BACKGROUND AND ANALYSIS	1
2.1	General Background	1
2.2	Case Law Relating to Euthanasia and Assisted Suicide	3
2.2.1	Definitions	3
2.2.2	The <i>Criminal Code</i> and Euthanasia	4
2.2.2.1	<i>R. v. Latimer</i>	4
2.2.3	The <i>Criminal Code</i> and Aiding Suicide.....	5
2.2.3.1	<i>Rodriguez v. British Columbia (Attorney General)</i>	5
2.2.3.2	<i>Carter v. Canada (Attorney General)</i>	6
2.2.4	An Act Respecting End of Life Care: Quebec	8
2.2.5	The Right to Refuse Medical Treatment.....	11
2.2.6	Advance Directives.....	11
2.2.7	Reports, Policies and Consultations.....	12
3	PARLIAMENTARY BILLS AND MOTIONS.....	15
4	CHRONOLOGY	17

EUTHANASIA AND ASSISTED SUICIDE IN CANADA *

1 INTRODUCTION

Because of advances in medical treatment, people are now able to live longer and to delay death. But the ability to live longer often entails a diminished quality of life for those who suffer from degenerative or incurable diseases. The desire to achieve greater control over decisions relating to life and death has been fuelled by a number of factors, including the wish to be spared from prolonged suffering and a better understanding of how medical technology can prolong life and affect the dying process. These factors have fostered an interest in euthanasia and assisted suicide, both of which are subject to a complete prohibition under Canada's *Criminal Code*.¹ A national poll conducted in 2015 found that 77% of Canadians sampled supported physician-assisted suicide for terminally ill individuals.²

In February 2015, the Supreme Court of Canada concluded in *Carter v. Canada (Attorney General)*³ that the *Criminal Code* provisions relating to aiding or abetting a person to commit suicide violate the *Canadian Charter of Rights and Freedoms* in certain situations of "physician-assisted death."⁴ In response to that decision, the federal government established an External Panel on Options for a Legislative Response to *Carter v. Canada* in July 2015. More recently, on 11 December 2015, Parliament established a Special Joint Committee of the Senate and the House of Commons. That committee will review the External Panel's report and "other recent relevant consultation activities and studies" and will

consult with Canadians, experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians.⁵

That committee is required to provide a final report to Parliament by 26 February 2016.

2 BACKGROUND AND ANALYSIS

2.1 GENERAL BACKGROUND

Despite the fact that euthanasia has gained considerable media attention of late, neither the practice itself nor the controversy it engenders is new. Although we now stress the conceptual distinctions between euthanasia, suicide and cessation of treatment, in early times euthanasia was generally equated with suicide.

The impact of scientific and medical discoveries in recent times has changed the nature of the debate on suicide. The increasing ability of physicians to treat bodily ailments and to extend life has caused the state to take a more direct interest in questions of life and death in the medical context.

In North America, the seminal case on the question of quality of life and cessation of treatment was that of Karen Ann Quinlan, a 21-year-old woman who suffered permanent brain damage, and went into a coma, after an episode involving the consumption of alcohol and drugs. Ms. Quinlan's parents signed a release form to allow physicians to withdraw the use of a respirator in the treatment of their daughter. When the hospital refused to follow the directive, her parents asked the courts to reverse the hospital's decision. In 1976, following a ruling by the New Jersey Supreme Court,⁶ the respirator was removed. Ms. Quinlan died in 1985 in a nursing home where she had remained in a coma, fed through tubes, for some 10 years.

In Canada, there have been two high-profile court cases involving women with amyotrophic lateral sclerosis (ALS) seeking the right to a physician-assisted death. ALS causes progressive muscle paralysis, chronic pain, and eventual death without affecting cognitive functioning. The cases of Sue Rodriguez and, more recently, Gloria Taylor represent key developments in the law in Canada and are discussed in more detail below.

The extent to which medical technology can prolong life, quite independently of considerations about the quality of that life, has become common knowledge for most citizens. This means that many persons give active consideration to the limits they will place on their own medical treatment and that of family members.

The increasing cost of health care is another relevant consideration. Estimates indicating that individuals incur their highest health care costs in the final days of life⁷ illustrate the delicate balance between sustaining life and containing health care expenses. This fact, some health policy analysts suggest, will become increasingly apparent as a greater proportion of the population moves into the older age groups, in which health care needs and their attendant costs increase.

Current proponents for the legalization of euthanasia and assisted suicide list a number of justifications, including:

- concerns for the personal autonomy and freedom of choice of individuals;
- limitations in the effectiveness of palliative care in alleviating the pain and suffering of all individuals;
- the argument that the law⁸ violates section 15 of the *Canadian Charter of Rights and Freedoms* (Charter) because able-bodied people may commit suicide but some with physical limitations cannot;⁹
- recognition that assisted suicide takes place despite its illegality and is occurring without adequate controls; and
- the argument that the distinction between withholding or withdrawing treatment (which are accepted practices) and assisted suicide does not stand up to scrutiny, as there is really no moral distinction between acts and omissions.¹⁰

In contrast, those who are against legalization often raise the following arguments:

- The fundamental social value of respect for life should be maintained, and killing is intrinsically wrong.
- Legalization could result in abuses, particularly with respect to vulnerable members of society.
- Individuals might in some cases seek assisted suicide under the pressure of insufficient financial and institutional resources.
- The “slippery slope” argument: allowing competent persons to access assisted suicide could lead to changes in the law with respect to incompetent persons, e.g., people under the age of 18 or those who are unable to make decisions for themselves for a variety of reasons, including mental illness.
- Legislation to permit euthanasia could limit developments to improve care for those who are dying, since advocating assisted suicide or euthanasia would be “quicker and easier” than conducting palliative care research.¹¹

2.2 CASE LAW RELATING TO EUTHANASIA AND ASSISTED SUICIDE

2.2.1 DEFINITIONS

Although the definitions used in discussions of euthanasia and assisted suicide can vary, the following definitions were used by the trial judge in *Carter*. “Euthanasia” is the “intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.” “Voluntary euthanasia” is euthanasia performed in accordance with the wishes of a competent person, expressed personally or by advance directive. “Non-voluntary euthanasia” refers to euthanasia performed when the wishes of the person are not known, and “involuntary euthanasia” is euthanasia performed against the wishes of the person in question.¹² “Assisted suicide” is “the act of intentionally killing oneself with the assistance of another person who provides the knowledge, means, or both” of doing so.¹³

In *Carter*, the plaintiff Gloria Taylor sought a “physician-assisted death,” as opposed to a physician-assisted suicide. According to the claimants in *Carter*, “physician-assisted dying” includes both “physician-assisted suicide,” which they defined as

an assisted suicide where assistance to obtain or administer medication or other treatment that intentionally brings about the patient’s own death is provided by a medical practitioner ... or by a person acting under the general supervision of a medical practitioner, to a grievously and irremediably ill patient in the context of a patient-physician relationship,¹⁴

and “consensual physician-assisted death,” which they defined as

the administration of medication or other treatment that intentionally brings about a patient’s death by the act of a medical practitioner ... or by the act of a person acting under the general supervision of a medical practitioner, at the request of a grievously and irremediably ill patient in the context of a patient-physician relationship.¹⁵

The claimants did not appear to make a distinction between “consensual physician-assisted death” and “voluntary euthanasia,” and the trial judge rejected their position that the meaning of the term “physician-assisted” should include “the provision of assistance by persons other than physicians.”¹⁶

2.2.2 THE *CRIMINAL CODE* AND EUTHANASIA¹⁷

Section 14 of the *Criminal Code* provides that:

No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 14 is relevant in cases of voluntary euthanasia. In the medical context, a doctor who, at a patient’s request, gives the patient a lethal injection (i.e., a physician participating in voluntary euthanasia) would be criminally liable. In *Carter*, the Supreme Court of Canada found that, in certain circumstances, section 14 violates section 7 of the Charter. See section 2.2.3.2 below for more about that decision.

One might expect euthanasia to be prosecuted as first-degree murder, because there is *intent* to cause death, which is required for a conviction of murder, and the act is most often *planned and deliberate*, which is required for a conviction of first-degree murder. However, charges of euthanasia have been influenced principally by other criteria: the fact that the primary intent is to relieve suffering; the unpredictable attitude of juries; and technical difficulties in proving the exact cause of death when a person is, in any case, close to death and receiving high doses of pain medication.

2.2.2.1 *R. v. LATIMER*

The most publicized euthanasia case in Canada involved Robert Latimer, who in 1993 killed his severely disabled daughter, Tracy, by exposing her to carbon monoxide. The Supreme Court of Canada noted that “[i]t was thought she experienced a great deal of pain.”¹⁸ She had multiple surgeries relating to her hip, and further painful surgery was anticipated. “Robert Latimer formed the view that his daughter’s life was not worth living.”¹⁹

Mr. Latimer was charged with first-degree murder and convicted of second-degree murder by a jury. After a series of trials and appeals, Mr. Latimer was granted leave to appeal by the Supreme Court of Canada on the grounds of whether the defence of necessity should have been left to the jury, whether the trial judge should have informed the jury that Mr. Latimer had the legal right to decide to commit suicide for his daughter as her surrogate decision-maker, and whether the minimum sentence for murder was, in violation of the Charter, cruel and unusual punishment in the circumstances.²⁰ In January 2001, the Court upheld the conviction and the sentence.²¹ It did, however, note that section 749 of the *Criminal Code* provides for the royal prerogative of mercy, which is a matter for the executive, not the courts, to consider.

In February 2008, the Appeal Division of the National Parole Board granted Mr. Latimer day parole, and he was released from prison in March of that year with conditions. The Board had initially denied his bid for parole in December 2007. In November 2010, Mr. Latimer was granted full parole.

2.2.3 THE *CRIMINAL CODE* AND AIDING SUICIDE

Under section 241 of the *Criminal Code*, it is an offence to counsel or to aid suicide. The Code specifies that:

Everyone who

- (a) counsels a person to commit suicide, or
- (b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

2.2.3.1 *RODRIGUEZ V. BRITISH COLUMBIA (ATTORNEY GENERAL)*

In 1992, Sue Rodriguez, a woman with ALS, challenged the validity of section 241(b) under the Charter. Ms. Rodriguez sought to have the section struck down on the grounds that it prohibits a terminally ill person from committing physician-assisted suicide. She argued that her right to “life, liberty and security of the person”²² – which, in her view, included the right to control the method, timing, and circumstances of death – were denied by section 241. At trial, Ms. Rodriguez lost. She appealed and lost again in a two-to-one decision.

Ms. Rodriguez appealed to the Supreme Court of Canada, which, in a five-to-four decision, dismissed the appeal.²³ Ms. Rodriguez argued that section 241(b) of the *Criminal Code*, which makes it an offence to aid or abet suicide, violated sections 7, 12 and 15 of the Charter.²⁴

The majority of the Court held that, although section 241(b) deprived Ms. Rodriguez of the security of her person under section 7 of the Charter, the deprivation was justified because it accorded with principles of fundamental justice. Writing for the majority, Justice Sopinka noted that respect for life is a fundamental principle on which there is substantial consensus in Canadian society. The prohibition against assisted suicide reflects this consensus and is designed to protect vulnerable persons who might be persuaded to commit suicide. To allow physician-assisted suicide, he observed, would erode the belief in the sanctity of human life and suggest that the state condones suicide. Furthermore, concerns about abuse and the difficulty in establishing safeguards to prevent abuse make it necessary to prohibit assisted suicide.

Also, the majority did not find that section 241(b) constituted cruel and unusual treatment under section 12 of the Charter.

Justice Sopinka assumed that Ms. Rodriguez’s equality rights under section 15(1) of the Charter had been infringed, but concluded that the infringement was justified under section 1 of the Charter. The purpose of section 241(b), he noted, is to protect individuals from others who may wish to control their lives. To create an exception to

the prohibition against assisted suicide for some groups or individuals would create inequality and lend support to the notion of a “slippery slope” toward full recognition of euthanasia. He considered the creation of safeguards to prevent abuse unsatisfactory and insufficient to calm fears of the likelihood of abuse. Even if an exception could be made for the terminally ill, he felt there could be no guarantee that assisted suicide could be limited to those who genuinely wished to die.

In her dissenting opinion, Madam Justice McLachlin held that section 241(b) violates section 7 of the Charter. She concluded that it would be contrary to the principles of fundamental justice to deny Ms. Rodriguez the choice available to those who are physically able, merely because of a fear that others might suffer abuse. She felt that Ms. Rodriguez was being treated as a “scapegoat” for others who might be improperly persuaded to commit suicide.

Chief Justice Lamer’s dissent was based on section 15(1) of the Charter. He concluded that section 241(b) creates an inequality in that physically disabled persons unable to commit suicide without assistance are prevented from choosing that option without breaking the law; those who are capable of ending their lives unassisted, however, may commit suicide with impunity. Although the Chief Justice was concerned that the decriminalization of assisted suicide might increase the risk for individuals vulnerable to manipulation by others, he contended that speculation to this effect and the fear of a “slippery slope” could not justify the restriction on those who are not vulnerable and who would freely consent to suicide.

In his dissent, Justice Cory agreed with the disposition of the appeal proposed by Chief Justice Lamer for the reasons put forward by the Chief Justice and Madam Justice McLachlin. He would have given the right to die with dignity protection under section 7 of the Charter and allowed terminally ill patients to obtain assistance to terminate their lives.

2.2.3.2 *CARTER V. CANADA (ATTORNEY GENERAL)*

On 15 June 2012, nearly 20 years after the Supreme Court released its decision in *Rodriguez*, a British Columbia court ruled that section 241(b) violates sections 7 and 15 of the Charter.²⁵ One of the plaintiffs was Gloria Taylor, a woman living with ALS. Other plaintiffs included the daughter and son-in-law of Kay Carter, who had travelled with Ms. Carter to Switzerland, where she sought physician-assisted suicide. The plaintiffs argued that section 241(b) violates the section 7 rights to life, liberty, and security of the person of the “grievously and irremediably ill” and, given the section’s disproportionate impact on physically disabled persons, violates the section 15 equality rights of people with physical disabilities.²⁶

Justice Smith was constrained by legal precedent in her decision. The principle of *stare decisis* (“to stand by that which is decided”) requires lower courts to follow the decisions of higher courts. Justice Smith held, however, that the *Rodriguez* precedent did not preclude her from finding in favour of the plaintiffs for a number of reasons. First, *Rodriguez* did not decide whether section 241(b) violates the equality rights of physically disabled people. Justice Smith reasoned that while the *Criminal Code* permits suicide, it prohibits assisted suicide, and this prohibition has a more

burdensome effect on people with physical disabilities, in that it perpetuates disadvantage and therefore violates section 15.²⁷ Justice Smith also noted that the Supreme Court added two principles of fundamental justice to its section 7 analysis since *Rodriguez*, and that this allowed her to find section 7 violations in respect of the individual plaintiffs.

Justice Smith declared section 241(b) invalid. She suspended her declaration for a year to allow Parliament to amend the legislation in compliance with the Charter. She also granted Gloria Taylor a constitutional exemption to permit her to seek physician-assisted suicide.

The governments of Canada and British Columbia appealed the trial judge's declaration that the sections of the *Criminal Code* relating to physician-assisted dying were invalid. The British Columbia Court of Appeal overturned the trial decision on 10 October 2013 in a two to one decision.²⁸ The majority did not consider the merits of the constitutional claims in any depth, focusing instead on the principle of *stare decisis*. The majority held that "the trial judge was bound to find that the plaintiffs' case had been authoritatively decided by *Rodriguez*"²⁹ and, further, that "[i]f the constitutional validity of s. 241 of the *Criminal Code* is to be reviewed notwithstanding *Rodriguez*, it is for the Supreme Court of Canada to do so."³⁰

Although the matter had become moot because of Ms. Taylor's death, the majority of the Court of Appeal held that the remedy of constitutional exemption would be appropriate for circumstances in which "a generally sound law ... has an extraordinary, even cruel, effect on a small number of individuals."³¹

The Supreme Court of Canada heard the appeal in *Carter* on 15 October 2014 and rendered its decision on 6 February 2015. The decision mentions the debate that has taken place in Canada and abroad since *Rodriguez* was decided, referring to private members' bills on the subject, the Special Senate Committee on Euthanasia and Assisted Suicide (1995), and international legislative developments.

The Supreme Court held that all three parts of section 7 (life, liberty and security of the person) were violated, and that the interference with those rights was not in accordance with the principles of fundamental justice. The Court also found that the prohibition could not be "saved" by section 1 of the Charter³² because the section 7 violation was not "minimally impairing," meaning that the objective of section 241(b) could have been achieved in a substantial manner without a blanket prohibition, therefore allowing certain individuals to access physician-assisted death. Specifically, the Court held that the evidence at trial indicated that a "permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error."³³

The Supreme Court held that, given its finding that there was a section 7 violation, it was "unnecessary to consider" whether there was a section 15 violation.³⁴

Having found an unjustifiable violation of section 7, the Supreme Court declared that sections 241(b) and 14 of the *Criminal Code*:

are void 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.³⁵

“Irremediable,” according to the Court, “does not require the patient to undertake treatments that are not acceptable to the individual.”³⁶ The Court noted further that the scope of its declaration responded to the facts in the case before it, and did not pronounce on other situations in which assisted death might be sought.³⁷

As noted above, the trial judge had granted Ms. Taylor a personal constitutional exemption to access physician-assisted dying. The Supreme Court concluded:

In view of the fact that Ms. Taylor has now passed away and that none of the remaining litigants seeks a personal exemption, this is not a proper case for creating [a mechanism for exemptions during the period of suspended validity].³⁸

The Court highlighted the concerns of some of the interveners that physicians’ freedom of conscience and religion (as protected by section 2(a) of the Charter) might be infringed if they were forced to participate in physician-assisted death, and stated that “nothing in the declaration of invalidity ... would compel physicians to provide assistance in dying,”³⁹ and that “the Charter rights of patients and physicians will need to be reconciled.”⁴⁰

Ultimately, the Court noted that “Parliament must be given the opportunity to craft an appropriate remedy,” and that “[c]omplex regulatory regimes are better created by Parliament than by the courts.”⁴¹

2.2.4 AN ACT RESPECTING END OF LIFE CARE: QUEBEC

In response to a 2009 discussion paper published by the Collège des médecins du Québec calling for the consideration of physician-assisted suicide as part of the spectrum of end-of-life care,⁴² the Quebec legislature struck the Select Committee on Dying with Dignity on 4 December 2009. The committee heard from 32 experts and more than 350 individuals and organizations and received 273 briefs during its work in 2010 and 2011.⁴³

In its submission to the committee, the Barreau du Québec recommended that the Attorney General develop guidelines for the prosecution of cases of euthanasia or assisted suicide. It claimed that, by using the provincial power to administer the criminal law and amending various provincial laws regulating health care services, it would be possible to provide a restricted and clearly defined right to euthanasia and assisted suicide in the province of Quebec without requiring any changes to the *Criminal Code*.⁴⁴

In March 2012, the Select Committee tabled its report.⁴⁵ It made 24 recommendations on palliative care, palliative sedation, advance medical directives, end-of-life care,

and medical aid in dying. Several recommendations called for legislative reform and many supported facilitating euthanasia.

In response to the committee report, the Quebec government appointed an expert panel to explore how to implement the recommended legislative changes. The panel released its report in January 2013.⁴⁶ The report advised that medical aid in dying be understood, in certain circumstances, as part of the continuum of care. When seen as an element of end-of-life care, medical aid in dying could fall into provincial jurisdiction over health care delivery.

On 12 June 2013, Bill 52, An Act respecting end-of-life care, was introduced in the Quebec National Assembly; it received Royal Assent on 5 June 2014.

The law establishes rights with respect to end-of-life care, rules for those who provide end-of-life care, rules relating to continuous palliative sedation, powers of the Minister of Health and Social Services (Minister), rules relating to advance medical directives, and rules relating to “medical aid in dying.” “Medical aid in dying” is defined as “care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient’s request, in order to relieve their suffering by hastening death.”⁴⁷

Section 26 of the Act establishes that, to obtain medical aid in dying, a patient must:

- be an insured person under the *Health Insurance Act* (meaning the patient must either be a resident of Quebec or a temporary resident who is registered with the Régie de l’assurance maladie du Québec);
- have attained the age of majority (18 in Quebec);
- have the capacity to consent to care;
- “be at the end of life”;
- “suffer from a serious and incurable illness”;
- “be in an advanced state of irreversible decline in capability”; and
- “experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.”⁴⁸

A patient must make a request for medical aid in dying using a form prescribed by the Minister.

Section 29 requires that before a physician may administer medical aid in dying, he or she must:

- be of the opinion that the patient meets the criteria set out above;
- ensure that the request is made freely;
- ensure that the patient is informed of the prognosis and therapeutic options;
- verify the persistence of suffering and the wish to proceed through discussions at “reasonably spaced intervals”;

- discuss the request with other members of the care team who are in regular contact with the patient and, if the patient wishes, with his or her close relations; and
- obtain a second opinion from a physician who is independent of both the patient and of the physician seeking the second opinion.⁴⁹

Section 31 provides that if the physician practising in an institution that operates pursuant to *The Act respecting health services and social services* or in a private health facility refuses the request for reasons not based on section 29, the physician must forward the form requesting medical aid in dying to the executive director of the institution or local authority, or to a designated person. The executive director is then required to find another physician who can deal with the request for medical aid in dying.

The Act also establishes a commission on end-of-life care (section 38), consisting of health and social services professionals, members of the legal profession, people who use institutions, an ethicist, and someone to represent institutions (section 39). The Commission's mandate includes advising the Minister; evaluating end-of-life care legislation; and, every five years, submitting a report on the status of end-of-life care to the Minister (section 42).

A physician who administers medical aid in dying must notify the Commission within 10 days and submit information prescribed by regulations (section 46). The Commission then reviews whether the physician has complied with established procedures (section 47).

Under section 50 of the Act, a physician who refuses to administer medical aid in dying because of his or her personal convictions must ensure that continuity of care is provided to the patient, and must follow the procedures for notifying the executive director of the institution or local authority (or other designated person) established in section 31.

Most of the Act's provisions were scheduled to come into force on 10 December 2015. However, on 1 December 2015, the Superior Court of Quebec declared that certain provisions of the law were in conflict with the federal *Criminal Code*, and that until the Supreme Court of Canada's declaration in *Carter* came into effect the paramountcy doctrine (which establishes that where there is an inconsistency or conflict between a federal and a provincial law, the federal law prevails) applies, rendering the provisions of Bill 52 that relate to medical aid in dying inoperative.⁵⁰ On 9 December 2015, leave to appeal was granted by the Quebec Court of Appeal, and that court suspended the procedures relating to the motion before the Superior Court of Quebec.⁵¹ The provisions in question are therefore in force as of 10 December 2015, pending any future decision by the Quebec Court of Appeal on the matter. It remains to be decided whether a doctor assisting in a death under the Quebec law would be subject to criminal proceedings, but the Quebec government has issued guidelines for prosecution in such cases.⁵²

2.2.5 THE RIGHT TO REFUSE MEDICAL TREATMENT

The common law recognizes the right of an adult, competent person to refuse medical treatment or to demand that treatment, once begun, be withdrawn or discontinued.

In 1990 in *Malette v. Shulman*,⁵³ the Ontario Court of Appeal held that instructions on blood transfusions issued when a patient was competent had to be followed even when that person was incapable of making a decision. The Court found that a physician must follow a Jehovah's Witness's written instruction refusing all blood transfusions, even in an emergency situation where the patient was unable to give consent. However, the Court emphasized that its decision applied only to the specific case before it, and not to situations of terminal or incurable illness in which a patient seeks to reject medical treatment by way of a living will or an advance medical directive; or situations in which the family of a person in a persistent vegetative state wishes to withdraw medical treatment.

In a January 1992 decision⁵⁴ in the case of Nancy B., the Quebec Superior Court ruled that a competent, adult patient suffering from an incurable disease and bedridden for life had the right to request that her doctor disconnect the respirator keeping her alive. In making his decision, Justice Dufour cited sections of the *Civil Code of Québec* that provide that the human person is inviolable and that no one can be made to undergo treatment without consent.

The case also dealt with the issue of the criminal liability of the physician who, at Nancy B.'s request, would be required to remove her from the respirator. After referring to sections 216, 217, 45 and 219 of the *Criminal Code*, as well as the provisions dealing with homicide, the judge concluded that it was neither unreasonable nor wanton and reckless conduct for a physician, at the request of a patient, to disconnect the patient's respirator and allow the patient's disease to take its natural course. The doctor would not be aiding the patient to commit suicide or committing an act of homicide, because Nancy B.'s death would result from the underlying disease.

2.2.6 ADVANCE DIRECTIVES

A number of provinces have sought to deal with the issue of medical treatment in the event of a patient's future incompetence. Advance directives have emerged as one response to the problem. Commonly known as a "living will," an advance directive is a document signed by a competent individual dealing with health care decisions to be made in the event that the person becomes incapable of making those decisions. In the *Civil Code of Québec*, an advance directive is referred to as a "mandate."

Advance directives can be divided into two categories:

- an instruction directive, in which an individual sets out *what types of treatment* he or she does not want in the event that he or she becomes incompetent; and
- a proxy directive, in which an individual sets out *who* is to make such health care decisions on his or her behalf.

Some jurisdictions outside Canada allow the use of advance directives to access assisted dying.⁵⁵

2.2.7 REPORTS, POLICIES AND CONSULTATIONS

Issues relating to euthanasia and assisted suicide were first considered in detail in Canada in 1983 when the Law Reform Commission of Canada published its report *Euthanasia, Aiding Suicide and Cessation of Treatment*.⁵⁶ That report followed a working paper on the subject that had been published by the Commission the previous year.

The Commission noted widespread consensus in Canada on three basic principles reflected in our law:

- The protection of human life is a fundamental value.
- The patient has the right to autonomy and self-determination in making decisions about his or her medical care.
- Human life needs to be considered from a quantitative and qualitative perspective.

Subsequent to the publication of its report, the Commission recommended that the *Criminal Code* contain a provision that no one has a duty to continue medical treatment that is therapeutically useless or for which consent is expressly refused or withdrawn. This recommendation, however, did not define “therapeutically useless” or set out the requirements for consent.

In November 1993, after the Supreme Court of Canada’s decision in the *Rodriguez* case, the British Columbia Ministry of the Attorney General issued guidelines for Crown Counsel with respect to charging individuals who, out of compassion for the deceased, participate in causing a death. Under the guidelines, Crown Counsel would approve a prosecution only where there is a “substantial likelihood of conviction and where prosecution is required in the public interest.”⁵⁷

In February 1994, the Senate of Canada established a special committee to study the issues of euthanasia and assisted suicide. Issued in June 1995, the committee’s report, entitled *Of Life and Death*, also canvassed a number of related issues, including palliative care, pain control and sedation practices, withholding and withdrawal of life-sustaining treatment, and advance directives.⁵⁸

The committee urged all levels of government in Canada to make palliative care programs a top priority and to develop national guidelines and standards for such care. The committee felt that there was no moral difference between withholding and withdrawing life-sustaining treatment. In either case, the wishes of a competent patient should be respected. The report recognized that there was uncertainty on the part of the medical profession and the public as to what is legally permissible and recommended that practice in the area be clarified in law.

The question of assisted suicide was more contentious. Some committee members favoured changes to the existing law, while others opposed such changes. A majority of the members recommended that the provision of the *Criminal Code* that proscribes aiding and abetting suicide remain intact.

The majority of the committee members opposed voluntary euthanasia, recommending that it remain a criminal offence, but with a less severe penalty in cases where mercy or compassion is an element. The minority recommended that the *Criminal Code* be amended to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide.

Non-voluntary euthanasia would also remain a criminal offence. However, the committee recommended that a less severe penalty be applied where compassion or mercy is an element. The committee was unanimous in its conclusion that involuntary euthanasia should continue to be treated as murder under the *Criminal Code*.

In November 1999, a Senate subcommittee was established to study developments with respect to the unanimous recommendations made in *Of Life and Death* in the five years after the report was published. The subcommittee submitted its report, entitled *Quality End-of-Life Care: The Right of Every Canadian*, in June 2000, concluding that “the principles, expertise, and medical infrastructure required for the care of people facing death were evolving far too slowly.”⁵⁹

In June 2010, then Senator Sharon Carstairs authored a report on the subject of palliative care, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*.⁶⁰ The report was inspired by her experiences on the special Senate committee mentioned above. *Raising the Bar* focused primarily on palliative care, but did mention euthanasia and assisted suicide as well.

In October 2009, the Royal Society of Canada established the Expert Panel on End-of-Life Decision Making. The Panel’s report, issued in November 2011, called for “a permissive yet carefully regulated and monitored system” to allow assisted death.⁶¹ In addition to many recommendations on end-of-life care, the Panel recommended amending the *Criminal Code* to permit euthanasia and assisted suicide. It argued that an initiative from Parliament through the criminal law would provide for the greatest consistency across the country, as well as certainty for Canadians with regard to their rights and responsibilities, and could allow for a national body to oversee assisted suicide and euthanasia in Canada.

The policy of the Canadian Medical Association (CMA) on euthanasia and assisted death has evolved over the years. Until recently, the policy prohibited participation in both euthanasia and assisted suicide. The most recent update to the policy states that:

There are rare occasions where patients have such a degree of suffering, even with access to palliative and end of life care, that they request medical aid in dying. In such a case, and within legal constraints, medical aid in dying may be appropriate.⁶²

In June 2015, the CMA released its draft *Principles-based Recommendations for a Canadian Approach to Assisted Dying*.⁶³

In mid-July 2015, the federal Minister of Justice and the federal Minister of Health announced the creation of a three-person external panel to consult directly with those who intervened in the Supreme Court of Canada case as well as with medical authorities.⁶⁴ Part of the panel's mandate was to propose options for a legislative response to the *Carter* decision. However, in a letter from the new Minister of Justice and the Minister of Health to the members of the External Panel after the 2015 federal election, the panel's mandate was revised such that the panel was requested instead to "prepare a report summarising the results and key findings of [their] consultations."⁶⁵

In mid-August 2015, the creation of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying was announced. The advisory group's work was to "complement the work of the federal panel"⁶⁶ and "provide advice on the development of policies, practices and safeguards for provinces and territories to consider when physician-assisted dying is legal within their respective jurisdictions."⁶⁷

The final report, dated 30 November 2015 and posted publicly on 14 December 2015, contained 43 recommendations.⁶⁸ Key recommendations include:

- establishing a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying;
- establishing a program within the publicly funded system that will link patients with an appropriate provider;
- amending the *Criminal Code* to allow physician-assisted dying by regulated health professionals acting under the direction of a physician or a nurse practitioner, and to protect health professionals who participate in physician-assisted dying;
- amending the *Criminal Code* to ensure that eligibility for physician-assisted dying is based on competence rather than age;
- having medical regulatory authorities develop guidance/tools for physicians;
- not requiring a mandatory waiting period between a request and provision of assistance in dying;
- requiring "conscientiously objecting" health care providers to inform patients of all end-of-life options, including physician-assisted dying, and requiring providers to give a referral or direct transfer of care or to contact a third party and transfer the patient's records;
- having provincial and territorial governments establish review committee systems to review compliance in all cases of physician-assisted dying;
- establishing a pan-Canadian Commission on End-of-Life Care (preferably in collaboration with the federal government); and
- providing public education about physician-assisted dying and engaging the public so that it can inform future developments of related law, policies and practices.

3 PARLIAMENTARY BILLS AND MOTIONS

Until 1991, when private members' bills on the subject were introduced in the House of Commons, euthanasia had received only fleeting references in the House and had never been debated there. Recent bills on the topic are discussed below. Bills that were introduced between 1991 and 2014 are listed in the Chronology to this paper.

On 15 June 2005, Bill C-407, An Act to amend the Criminal Code (right to die with dignity) was introduced by Francine Lalonde (La Pointe-de-l'Île).⁶⁹ Because of the dissolution of Parliament and the call of the federal election, a planned vote on the bill did not take place. Bill C-407 would have amended sections 14 (Consent to Death), 222 (Homicide), and 241 (Counselling or aiding suicide) of the *Criminal Code* so that, provided that certain criteria were met, a person who assists another person to die would be neither committing a homicide nor counselling or aiding suicide. The bill would have required that the individual whose death is assisted:

- be at least 18 years old;
- be either experiencing "severe physical or mental pain without any prospect of relief" or terminally ill;
- have, while appearing to be lucid, made two requests more than 10 days apart stating his or her free and informed wish to die; and
- have designated in writing someone to act for him or her "with respect to the person who aids him or her to die, and with respect to any medical practitioner" in the event that the individual appears not be lucid.

The bill would also have required that the person who is assisting the death:

- be a medical practitioner or be assisted by a medical practitioner;
- have received confirmation of the diagnosis from one or two medical practitioners (depending on whether the person assisting the death is a medical practitioner);
- be entitled by law to provide health services or be assisted by a team of people so entitled;
- act as directed by the individual whose death is assisted; and
- provide the coroner with a copy of the diagnosis from one or two medical practitioners (depending on whether the person assisting the death is a medical practitioner).

Ms. Lalonde introduced two more or less identical bills, though they would have allowed only a medical practitioner to legally aid a person to die (Bill C-562 in 2008 and Bill C-384 in 2009). Neither bill was successful.⁷⁰

On 27 March 2014, two private member's bills were introduced by the Honourable Steven Fletcher. Bill C-581, An Act to amend the Criminal Code (physician-assisted death) would have amended section 14 of the *Criminal Code* to provide exceptions to consenting to death as provided for in a new section 241.1.⁷¹ The bill also would have exempted a physician from the application of section 241 of the *Criminal Code* if certain requirements were met. The criteria in the bill essentially mirror those adopted by the trial judge in *Carter*.

Under proposed new section 241.1(3), to be eligible for physician-assisted death, a person had to:

- be 18 years or older;
- a citizen or permanent resident;
- “have been diagnosed by a physician as having an illness, a disease or a disability (including disability arising from traumatic injury) that causes physical or psychological suffering that is intolerable to that person and that cannot be alleviated by any medical treatment acceptable to that person, or the person must be in a state of weakening capacities with no chance of improvement”; and
- be competent for consent to treatment purposes.

Both the physician who would assist with the death and a consulting physician must examine the person making a request for physician-assisted death (proposed new section 241.1(4)). The assisting physician must notify the patient of the medical diagnosis and prognosis, consequences of the request, alternative treatments, and the right to revoke the request (proposed new section 241.1(6)).

Proposed new section 241.1(9) of the bill would have required that 14 days elapse between the time the request is signed and the time the request is carried out.

The bill also set out documentation requirements in proposed new section 241.1(12).

Mr. Fletcher’s second bill, Bill C-582, An Act to establish the Canadian Commission on Physician-Assisted Death, would have established a Commission, “the purpose of which is to produce public information on physician-assisted death and to support law and policy reform with respect to physician-assisted death.”⁷² Among other things, the Commission’s responsibilities were to include developing a form to gather information about physician-assisted deaths, and collecting and analyzing data from the completed forms. The Commission would have also made recommendations to the Attorney General of Canada with respect to law and policy reform on the subject of physician-assisted death in Canada.

On 2 December 2014, Senator Nancy Ruth introduced Bill S-225, An Act to amend the Criminal Code (physician-assisted death).⁷³ The bill would have replaced the existing section 14 of the *Criminal Code* to state that a person can consent to voluntary euthanasia by making a request for physician-assisted death, and that voluntary euthanasia performed by a physician in accordance with a new section 241.1 is not culpable homicide. The criteria for accessing physician-assisted death are the same as in Mr. Fletcher’s bill, with the addition that the individual seeking physician-assisted death must “be acting voluntarily, free from coercion or undue influence” (proposed new section 241.1(3)(e)).

All three bills died with the dissolution of Parliament at the call of the federal election on 2 August 2015.

On 24 February 2015, Justin Trudeau, leader of the Liberal Party of Canada, moved in the House of Commons that a special committee be established to consider the *Carter* decision, hold consultations and make recommendations, but that motion was defeated.⁷⁴

As was mentioned in the Introduction, on 11 December 2015, a motion was passed in the House of Commons to establish a Special Joint Committee of the Senate and the House of Commons. That motion stated that the committee's purpose is:

to review the report of the External Panel on Options for a Legislative Response to *Carter v. Canada* and other recent relevant consultation activities and studies, to consult with Canadians, experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians.

The motion also stated that “the Committee be directed to consult broadly, take into consideration consultations that have been undertaken on the issue, examine relevant research studies and literature and review models being used or developed in other jurisdictions.”⁷⁵

4 CHRONOLOGY

1983	The Law Reform Commission of Canada recommended against legalizing or decriminalizing voluntary active euthanasia. It also recommended that aiding suicide not be decriminalized where assistance has been rendered to a terminally ill person.
June 1987	The Law Reform Commission of Canada released proposals for amending the <i>Criminal Code</i> . These included the recommendation that mercy killing be treated as second-degree murder (“ordinary murder”) rather than as first-degree murder (“premeditated murder”).
March 1991	Bill C-351, An Act to amend the Criminal Code (terminally ill persons), introduced by Robert Wenman, passed first reading in the House of Commons. The bill expired with the prorogation of Parliament.
May 1991	Bill C-203, An Act to amend the Criminal Code (terminally ill persons), introduced by Robert Wenman, passed first reading in the House of Commons.
June 1991	Bill C-261, An Act to legalize the administration of euthanasia under certain conditions, introduced by Chris Axworthy, passed first reading in the House of Commons.
September 1991	Bill C-203, An Act to amend the Criminal Code (terminally ill persons) received second reading and was referred to Legislative Committee H for consideration. The Committee began hearings on the bill on 29 October 1991.

October 1991	Bill C-261, An Act to legalize the administration of euthanasia under certain conditions to persons who request it and who are suffering from an irremediable condition and respecting the withholding and cessation of treatment and to amend the Criminal Code, was debated at second reading and dropped from the <i>Order Paper</i> .
January 1992	The Quebec Superior Court ruled in the case of Nancy B., a woman suffering from an incurable disease, that turning off her respirator at her request and letting nature take its course would not be a criminal offence.
January 1992	An Ontario surgeon was charged with second-degree murder in connection with the death of a seriously ill cancer patient. The patient is alleged to have died of a cardiac arrest after having been administered morphine and potassium chloride.
February 1992	Legislative Committee H on Bill C-203 adjourned.
August 1992	Scott Mataya, a Toronto nurse who had originally been charged with first-degree murder in the mercy killing of a terminally ill patient, entered a guilty plea to a lesser charge of administering a noxious substance. He received a suspended sentence and was ordered to surrender his nursing licence.
December 1992	Bill C-385, An Act to amend the Criminal Code (aiding suicide), introduced by Svend Robinson, passed first reading in the House of Commons. The bill expired with the prorogation of Parliament.
March 1993	Members of the House of Commons defeated a motion that called upon the government to consider the advisability of introducing legislation on the subject of euthanasia and ensuring that those assisting terminally ill persons who wish to die will not be subject to criminal liability.
April 1993	An Ontario physician who gave a lethal injection to a seriously ill cancer patient was given a three-year suspended sentence after pleading guilty to a charge of administering a noxious substance to endanger life. The physician was originally charged with second-degree murder, but this charge was withdrawn.
September 1993	In a five-to-four decision, the Supreme Court of Canada dismissed an appeal by Sue Rodriguez in which she challenged the validity of the <i>Criminal Code</i> prohibition on assisted suicide under the Charter.
November 1993	The British Columbia Ministry of the Attorney General issued guidelines for Crown Counsel with respect to charging persons involved in cases of active euthanasia and assisted suicide.

- February 1994 Sue Rodriguez committed suicide with the assistance of a physician. The death was investigated by police, but no criminal charge was laid.
- February 1994 Justice Minister Allan Rock stated that the issues of cessation of treatment and assisted suicide should be considered by Parliament.
- February 1994 Prime Minister Chrétien stated that members of Parliament would have a free vote on whether to legalize doctor-assisted suicide.
- February 1994 Bill C-215, An Act to amend the Criminal Code (aiding suicide), introduced by Svend Robinson, passed first reading in the House of Commons. This bill was debated and dropped from the *Order Paper* on 21 September 1994.
- February 1994 A Special Senate Committee was established to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide.
- November 1994 Robert Latimer was convicted of second-degree murder in the asphyxiation of his severely disabled 12-year-old daughter Tracy and sentenced to life in prison with no eligibility for parole for 10 years.
- June 1995 The Special Senate Committee on Euthanasia and Assisted Suicide issued its report entitled *Of Life and Death*.
- November 1996 Bill S-13, An Act to amend the Criminal Code (protection of health care providers), was introduced in the Senate by Senator Sharon Carstairs. The bill expired with the prorogation of Parliament.
- February 1997 The Supreme Court of Canada ordered a new trial for Robert Latimer.
- May 1997 Dr. Nancy Morrison was charged with the first-degree murder of a terminally ill patient who had been removed from active life support.
- December 1997 Robert Latimer, having again been convicted of second-degree murder, was sentenced to two years less a day, notwithstanding that the minimum sentence under the *Criminal Code* is life in prison with no possibility of parole for 10 years.
- February 1998 A Nova Scotia judge found that there was not sufficient evidence for a jury to convict Dr. Nancy Morrison, and refused to commit her to trial.

May 1998	Dr. Maurice Généreux was sentenced to two years less a day and three years' probation for providing drugs to two non-terminal patients so that they might commit suicide. The next year, that sentence was confirmed by the Ontario Court of Appeal.
November 1998	The Saskatchewan Court of Appeal confirmed the conviction of Robert Latimer and imposed a sentence of life imprisonment with no eligibility for parole for 10 years.
November 1998	An appeal of the decision in Dr. Nancy Morrison's case was dismissed by the Nova Scotia Supreme Court.
April 1999	Bill S-29, An Act to amend the Criminal Code (Protection of Patients and Health Care Providers), was introduced in the Senate by Senator Thérèse Lavoie-Roux. The bill expired with the prorogation of Parliament.
October 1999	Bill S-2, An Act to facilitate the making of legitimate medical decisions regarding life-sustaining treatments and the controlling of pain, was introduced in the Senate by Senator Sharon Carstairs. It was referred to the Standing Senate Committee on Legal and Constitutional Affairs in February 2000, but was not reported back before the dissolution of Parliament.
June 2000	The Senate Subcommittee studying developments with respect to the unanimous recommendations made in <i>Of Life and Death</i> in 1995 submitted its report, entitled <i>Quality End-of-Life Care: The Right of Every Canadian</i> .
January 2001	The Supreme Court of Canada upheld the decision of the Saskatchewan Court of Appeal with regard to Robert Latimer.
September 2004	Marielle Houle was charged with aiding and abetting the suicide of her 36-year-old son, Charles Fariala.
November 2004	Evelyn Martens was acquitted of aiding and abetting the suicides of two women that took place in 2002.
June 2005	Bill C-407, An Act to amend the Criminal Code (right to die with dignity) was introduced by Francine Lalonde.
July 2005	André Bergeron was charged with the attempted murder of his spouse, Marielle Gagnon, who had Friedreich's ataxia.
October 2005	Bill C-407 was given one hour of debate in the House of Commons. It died on the <i>Order Paper</i> in November 2005 with the dissolution of Parliament.
January 2006	Marielle Houle pled guilty to aiding and abetting the suicide of her son, and was sentenced to three years' probation.

September 2006	Raymond Kirk pled guilty to aiding the suicide of his ailing wife. The Ontario Court of Justice sentenced him to three years' probation.
October 2006	André Bergeron was sentenced to three years' probation for aggravated assault in relation to the death of his wife.
June 2007	Dr. Ramesh Kumar Sharma was sentenced for aiding the suicide of Ruth Wolfe, a 93-year-old woman who suffered from heart problems. The court imposed a sentence of two years less a day to be served in the community.
July 2007	The RCMP decided not to lay charges in the assisted suicide case of Elizabeth MacDonald, a Canadian with multiple sclerosis who died in Switzerland with the assistance of the organization Dignitas.
February 2008	The Appeal Division of the National Parole Board granted Robert Latimer day parole.
June 2008	MP Francine Lalonde introduced Bill C-562, An Act to amend the Criminal Code (right to die with dignity).
September 2008	Bill C-562 died on the <i>Order Paper</i> with the dissolution of Parliament.
December 2008	Stéphan Dufour was acquitted by a jury of assisting his uncle to commit suicide, due to Mr. Dufour's limited mental capacity. An appeal by the prosecution was unsuccessful.
May 2009	Ms. Lalonde introduced Bill C-384, which is identical to Bill C-562. It was defeated on 21 April 2010 by a vote of 228 to 59.
December 2009	The Quebec legislature mandated a Select Committee on Dying with Dignity to consult the public in that province.
May 2010	Peter Fonteece pled guilty to criminal negligence causing death because he did not seek assistance for his wife when she killed herself as part of their suicide pact. He was not found guilty of assisting in her suicide.
June 2010	Senator Sharon Carstairs authored a report on the subject of palliative care, <i>Raising the Bar: A Roadmap for the Future of Palliative Care in Canada</i> .
November 2010	Robert Latimer was granted full parole.

November 2011	The Royal Society of Canada published <i>End-of-Life Decision Making</i> .
March 2012	Quebec's Select Committee on Dying with Dignity tabled its report, recommending legislative reform to facilitate euthanasia.
June 2012	The B.C. Supreme Court heard Gloria Taylor's challenge to section 241(b) of the <i>Criminal Code</i> and declared the section invalid.
January 2013	A Quebec expert panel recommended amending health care legislation to treat euthanasia as part of end-of-life care.
June 2013	Bill 52, An Act respecting end-of-life care, was introduced in the Quebec National Assembly.
October 2013	The B.C. Court of Appeal overturned the trial judge's decision in <i>Carter v. Canada (Attorney General)</i> .
March 2014	MP Steven Fletcher introduced Bill C-581, An Act to amend the Criminal Code (physician-assisted death) and Bill C-582, An Act to establish the Canadian Commission on Physician-Assisted Death.
December 2014	Senator Nancy Ruth introduced Bill S-225, An Act to amend the Criminal Code (physician-assisted death).
February 2015	The Supreme Court of Canada declared s. 14 and s. 241(b) to be contrary to the <i>Canadian Charter of Rights and Freedoms</i> in certain circumstances, but suspended that declaration for one year to allow Parliament, the provinces and territories to legislate.
February 2015	The Leader of the Liberal Party, Justin Trudeau, moved in the House of Commons that a special committee be established to examine the decision in <i>Carter v. Canada (Attorney General)</i> , but the motion was not successful.
June 2015	The Canadian Medical Association issued the draft <i>Principles-based Recommendations for a Canadian Approach to Assisted Dying</i> .
July 2015	The federal government established the External Panel on Options for a Legislative Response to <i>Carter v. Canada</i> .
August 2015	A provincial-territorial expert advisory group on physician-assisted suicide was established.
December 2015	Provisions of Quebec's Bill 52, An Act respecting end-of-life care, came into force (pending a decision by the Quebec Court of Appeal as to whether the provisions conflict with the federal <i>Criminal Code</i>).

December 2015	The Special Joint Committee of the Senate and the House of Commons was established.
December 2015	The Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying was released.
December 2015	The External Panel on Options for a Legislative Response to <i>Carter v. Canada</i> completed its final report.

NOTES

- * This is a revised version of a publication of the same title, which was prepared on 15 March 2013 and to which Dominique Valiquet, of the Library of Parliament, and Martha Butler, formerly of the Library of Parliament, contributed.
1. [Criminal Code](#), R.S.C. 1985, c. C-46.
 2. Forum Research Inc., “[Support for assisted suicide increases across four years](#),” News release, 25 August 2015.
 3. [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5.
 4. For a more detailed discussion of the decision in *Carter v. Canada (Attorney General)*, see Martha Butler and Marlisa Tiedemann, [Carter v. Canada: The Supreme Court of Canada’s Decision on Assisted Dying](#), Publication no. 2015-47-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 7 October 2015.
 5. House of Commons, [Debates](#), 1st Session, 42nd Parliament, 11 December 2015, 1015.
 6. [In the Matter of Karen Quinlan, an Alleged Incompetent](#), 70 N.J. 10 (1976).
 7. See for example, Peter Tanuseputro et al., “[The Health Care Cost of Dying: A Population-Based Retrospective Cohort Study of the Last Year of Life in Ontario, Canada](#),” *PLoS ONE*, 10(3): e0121759, 26 March 2015.
 8. Euthanasia and assisted suicide are prohibited under the *Criminal Code*; the relevant sections of the Act are discussed below.
 9. Note that this argument was rejected by the Supreme Court of Canada in [Rodriguez v. British Columbia \(Attorney General\)](#), [1993] 3 S.C.R. 519. It was successful, however, in [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886. The Supreme Court of Canada found that it was not necessary to consider this argument in its decision in *Carter*.
 10. Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, University of Toronto Press, Toronto, 2004, pp. 86, 88, 97.
 11. Margaret A. Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*, McGill-Queen’s University Press, Montréal, 2001, p. 82.
 12. [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886, para. 38.
 13. *Ibid.*, para. 37. Definitions found in this paper follow those used in the judgment in the *Carter* case. Also of note, the terminology used for assisted suicide can be controversial, and some supporters of the practice prefer terms such as “death with dignity” or “aid in dying.”
 14. *Ibid.*, para. 23.
 15. *Ibid.*

16. *Ibid.*, para. 1389.
17. The focus of this section is on the criminal law issues relating to euthanasia and assisted suicide. If both or either were legalized, this would affect a number of other areas of law and regulation that are primarily within provincial jurisdiction, such as the administration of the court system, health law, ethics codes for health professionals and human rights legislation.
18. [R. v. Latimer](#), [2001] 1 S.C.R. 3, para. 6.
19. *Ibid.*, para. 13.
20. Section 12 of the [Canadian Charter of Rights and Freedoms](#) states that “Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.”
21. *R. v. Latimer*.
22. Section 7 of the *Canadian Charter of Rights and Freedoms* states that “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.”
23. [Rodriguez v. British Columbia \(Attorney General\)](#), [1993] 3 S.C.R. 519.
24. Section 15(1) of the *Canadian Charter of Rights and Freedoms* states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit 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.
25. *Carter v. Canada (Attorney General)*, 2012 BCSC 886.
26. The summary of the decision is taken from Butler and Tiedemann (2015).
27. [Withler v. Canada](#), 2011 SCC 12.
28. [Carter v. Canada \(Attorney General\)](#), 2013 BCCA 435.
29. *Ibid.*, para. 324.
30. *Ibid.*, para. 352.
31. *Ibid.*, para. 326.
32. Section 1 of the Charter states: “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.”
33. *Carter v. Canada (Attorney General)*, 2015 SCC 5, para. 105.
34. *Ibid.*, para. 93.
35. *Ibid.*, para. 127.
36. *Ibid.*
37. *Ibid.*
38. *Ibid.*, para. 129.
39. *Ibid.*, para. 132.
40. *Ibid.*
41. *Ibid.*, para. 125. Information about prosecutions under section 241(b) of the *Criminal Code* can be found in the chronology at the end of this paper, although that is not an exhaustive list.

42. Collège des médecins du Québec, [*Physicians, Appropriate Care and the Debate on Euthanasia – A Reflection*](#), 16 October 2009.
43. Select Committee on Dying with Dignity [Select Committee], [*Dying with Dignity*](#), March 2012, p. 13.
44. Barreau du Québec, [*Pour des soins de fin de vie respectueux des personnes*](#), Montréal, September 2010.
45. Select Committee (2012).
46. Jean-Pierre Ménard, Michelle Giroux, and Jean-Claude Hébert, [*Mettre en œuvre les recommandations de la Commission spéciale de l'Assemblée nationale sur la question de mourir dans la dignité : Rapport du Comité de juristes experts*](#), January 2013.
47. [*An Act Respecting End-of-Life Care*](#), RSQ, c. S-32.0001, s. 3(6).
48. *Ibid.*, s. 26.
49. *Ibid.*, s. 29.
50. [*D'Amico c. Québec \(Procureure générale\)*](#), 2015 QCCS 5556. [Available in French only.]
51. [*Québec \(Procureure générale\) c. D'Amico*](#), 2015 QCCA 2138. [Available in French only.]
52. Quebec Minister of Justice, "[*Avis – Orientations et mesures de la ministre de la Justice*](#)," 9 December 2015. [Available in French only.]
53. [*Malette v. Shulman \(Ont. C.A.\)*](#), 1990 CanLII 6868 (ON CA).
54. *Nancy B. v. Hôtel-Dieu de Québec (1992)*, 86 D.L.R. (4th) 385 (Que. S.C.).
55. For information on jurisdictions that allow the use of advance directives to authorize assisted dying, see Julia Nicol and Marlisa Tiedemann, [*Euthanasia and Assisted Suicide: The Law in Selected Countries*](#), Publication no. 2015-116-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 23 October 2015.
56. Law Reform Commission of Canada, [*Euthanasia, Aiding Suicide and Cessation of Treatment*](#), Report 20, Ottawa, 1983.
57. British Columbia Ministry of the Attorney General, "[*Euthanasia and Assisted Suicide*](#)," Policy EUT 1 in *Crown Counsel Policy Manual*, 15 March 2004, p. 1.
58. Senate, Special Committee on Euthanasia and Assisted Suicide, [*Of Life and Death – Final Report*](#), June 1995.
59. Senate, Subcommittee to Update *Of Life and Death*, [*Quality End-of-Life Care: The Right of Every Canadian*](#), Final Report, June 2000, p. 3.
60. The Honourable Sharon Carstairs, [*Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*](#), Senate of Canada, June 2010.
61. Udo Schuklenk et al., [*The Royal Society of Canada Expert Panel: End-of-Life Decision Making*](#), The Royal Society of Canada, November 2011, p. 9.
62. Canadian Medical Association [CMA], "[*CMA Policy: Euthanasia and Assisted Death \(Update 2014\)*](#)."
63. For a summary of the draft document, see Butler and Tiedemann (2015). The draft document was revised slightly and included as part of the CMA's submission to the External Panel on Options for a Legislative Response to *Carter v. Canada*: CMA, Letter to the Members of the Federal External Panel ("[*Re: CMA Submission to the Federal External Panel on Options for a Legislative Response to Carter vs. Canada \(Federal External Panel\)*](#)"), 19 October 2015.

64. Department of Justice, "[Government of Canada Establishes External Panel on options for a legislative response to *Carter v. Canada*](#)," News release, Ottawa, 17 July 2015. See also Butler and Tiedemann (2015).
65. Government of Canada, "[Letter from Minister Wilson-Raybould and Minister Philpott to the External Panel on Options for a Legislative Response to *Carter v. Canada*](#)," Backgrounder, 14 November 2015.
66. Government of Ontario, "[Provinces, Territories Establish Expert Advisory Group On Physician-Assisted Dying](#)," News release, 14 August 2015. See also Butler and Tiedemann (2015).
67. Ibid.
68. Provincial–Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report*, 30 November 2015.
69. [Bill C-407: An Act to amend the Criminal Code \(right to die with dignity\)](#), 1st Session, 38th Parliament.
70. [Bill C-562: An Act to amend the Criminal Code \(right to die with dignity\)](#), 2nd Session, 39th Parliament; and [Bill C-384: An Act to amend the Criminal Code \(right to die with dignity\)](#), 2nd Session, 40th Parliament.
71. [Bill C-581: An Act to amend the Criminal Code \(physician-assisted death\)](#), 2nd Session, 41st Parliament.
72. [Bill C-582: An Act to establish the Canadian Commission on Physician-Assisted Death](#), 2nd Session, 41st Parliament.
73. [Bill S-225: An Act to amend the Criminal Code \(physician-assisted death\)](#), 2nd Session, 41st Parliament.
74. House of Commons, *Debates*, 2nd Session, 41st Parliament, 24 February 2015, 1010.
75. House of Commons (11 December 2015), 1015.