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# Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)

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## Introduction – Brief Summary of *Carter v Canada*

In *Carter*,[1] the Supreme Court of Canada (the "Court") held that the criminal laws prohibiting assistance in dying limited the rights to life, liberty and security of the person under section 7 of the *Canadian Charter of Rights and Freedoms* (the "*Charter*") in a manner that was not demonstrably justified under section 1 of the *Charter*. The *Criminal Code* provisions at issue were paragraph 241(b), which prohibits assisting suicide, and section 14, which provides that no person may consent to death being inflicted on them.

*Life, Liberty and Security of the Person*

Consistent with its earlier *Rodriguez* decision,[2] the Court held that the laws prohibiting physician-assisted dying interfere with the liberty and security of the person of individuals who have a grievous and irremediable medical condition.[3] They interfere with liberty by constraining the ability of such individuals to make decisions concerning their bodily integrity and medical care, and with security of the person by leaving such individuals to endure intolerable suffering. The Court also held that the laws deprive some people of life by forcing them to take their own lives prematurely for fear that they would be incapable of doing so when they reached a point where their suffering was intolerable.

*Principles of Fundamental Justice*

In order to comply with section 7 of the *Charter*, a deprivation of life, liberty or security of the person must accord with the principles of fundamental justice. The principles at issue in *Carter* were those against arbitrariness, overbreadth and gross disproportionality. An arbitrary law is one that "exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law."[4] An overbroad law is one that may be rational in general but denies the rights of some individuals in a way that bears no relation to the legislative purpose. A grossly disproportionate law is one that, while it may further the legislative objective, has negative effects on life, liberty or security of the person that are so extreme as to be "totally out of sync" with the object of the law.[5]

The Court held that the prohibition on assistance in dying is not arbitrary because it "clearly helps achieve" the legislative objective of protecting vulnerable persons from being induced to die by suicide at a moment of weakness.[6] However, the prohibition was found to be overbroad because it applies to individuals who are not vulnerable, thereby denying the rights of some people in a way that bears no relation to the purpose of the law. The Court found it unnecessary to decide the issue of gross disproportionality in view of its conclusion that the prohibition is overbroad.

*Section 1*

Limitations of *Charter* protections are constitutional if they are reasonable and demonstrably justified pursuant to section 1 of the *Charter*. The Court concluded that the section 7 limitation was not justified. Although the Court accepted that the absolute prohibition on assistance in dying furthers a pressing and substantial objective, it concluded that a permissive regime with

properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error and that the absolute prohibition goes farther than reasonably necessary to achieve the legislative purpose.

*Remedy*

The Court explained that the appropriate remedy was:

> a declaration that s. 241(b) and s. 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.[7]

The Court went on to specify that the scope of the declaration was "intended to respond to the factual circumstances in this case" and to highlight that it was making "no pronouncement on other situations where physician-assisted dying may be sought."[8] The factual circumstances that were the focus of the Court's analysis were those of Gloria Taylor, who suffered from amyotrophic lateral sclerosis (ALS), a fatal neurodegenerative disease.[9] The Court noted elsewhere in the judgment that assistance in dying in other situations, such as for "minors or persons with psychiatric disorders or minor medical conditions" would not fall within the parameters suggested in its reasons.[10]

The Court suspended the declaration of invalidity for 12 months to give Parliament and provincial legislatures time to respond. It acknowledged that the legislative response would likely involve a "complex regulatory regime" and that Parliament "faces a difficult task" in balancing the competing social interests of those who might be at risk in a permissive regime against those who seek assistance in dying.[11] It also suggested that a high degree of deference would be owed to the regime ultimately adopted by Parliament.[12]

On January 15, 2016, the Court granted a four-month extension of the suspension, with the result that the declaration of invalidity took effect on June 7, 2016.[13]

## Part 1 – Description of Legislation on Medical Assistance in Dying

The development of the legislation on medical assistance in dying (Bill C-14) was informed by the evidence before all levels of court in the *Carter* case,[14] by available Canadian and international research, social science evidence, governmental reports and parliamentary studies.[15] It was also informed by the experience of existing international medical assistance in dying regimes, as well as by numerous recent consultative activities on such assistance, including the work of the Special Joint Committee on Physician-Assisted Dying,[16] the External Panel on Options for a Legislative Response to *Carter v Canada*,[17] the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying,[18] the Canadian Medical Association,[19] the College of Family Physicians of Canada,[20] and the work of provincial colleges of physicians and surgeons, among others. Bill C-14 received Royal Assent on June 17, 2016.

Bill C-14 strikes the most appropriate balance between the autonomy of those individuals seeking access to medical assistance in dying and the interests of vulnerable persons and of society, through amendments to the *Criminal Code* to allow physicians and nurse practitioners to provide assistance in dying to eligible competent adults in accordance with specified safeguards. The legal effect of the new legislation is to de-criminalize medical assistance in dying and leave further regulation of the practice to the provinces and territories (PTs) should they so choose. Medical assistance in dying has aspects that fall under both federal and provincial jurisdiction. The criminal law aspects of such assistance fall under exclusive federal jurisdiction and apply consistently across the country. The PTs can legislate in relation to the health care aspects and civil law implications so long as PT legislation does not conflict with the criminal law. From a federal perspective, a reasonable degree of consistency across and within provinces and territories would support the underlying values and principles of the *Canada Health Act* – that is, that all Canadians should have access to needed health care services, which could include services related to medical assistance in dying, without financial or other barriers.

## I. Legislative Objectives

The objectives of the legislation are expressly stated in the preamble of Bill C-14 and include:

- recognizing the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering to seek medical assistance in dying;
- recognizing that robust safeguards, which reflect the irrevocable nature of ending a life, are essential to prevent error and abuse in the provision of medical assistance in dying;
- affirming the inherent and equal value of every person's life and avoiding encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled;
- protecting vulnerable persons from being induced, in moments of weakness, to end their lives;
- recognizing that suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities;
- recognizing that permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other;
- recognizing that a consistent approach to medical assistance in dying across Canada is desirable, while recognizing the provinces' jurisdiction over various matters related to medical assistance in dying, including the delivery of health care services and the regulation of health care professionals, as well as insurance contracts, coroners and medical examiners;
- recognizing that those who wish to access medical assistance in dying should be able to do so without adverse legal consequences on their families;
- recognizing that everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms* and that nothing in the Bill affects those freedoms (as amended by the House of Commons Standing Committee on Justice and Human Rights);

- recognizing the Government of Canada's commitment to working with provinces, territories and civil society to facilitate access to palliative and end-of-life care, care and services for individuals living with Alzheimer's and dementia, appropriate mental health supports and services and culturally and spiritually appropriate end-of-life care for Indigenous patients (as amended by the House of Commons Standing Committee on Justice and Human Rights).

The preamble also affirms the Government's commitment to uphold the principles set out in the *Canada Health Act* and to develop non-legislative measures to support the improvement of a full range of options for end-of-life care and respect the personal convictions of health care providers. In this regard, the Minister of Health has committed to develop, in collaboration with the PTs, an end-of-life care coordination system to provide information on options and facilitate patient access to care.

The legislative objectives in the preamble speak to the circumstances for which medical assistance in dying would be made available, but they also speak to the reasons why access would not be permitted in other circumstances. For example, the objective of recognizing that suicide is a public health issue helps to explain why medical assistance in dying is not presently being contemplated for people who are not approaching a natural death. To permit it in circumstances where a person is not approaching natural death could be seen as undermining suicide prevention initiatives and normalizing death as a solution to many forms of suffering.

That said, the preamble also recognizes the Government of Canada's commitment to explore additional circumstances in which a person may seek access to medical assistance in dying, namely requests by mature minors, advance requests, and where mental illness is the sole underlying medical condition. These circumstances are complex, and require additional study and consideration. The Bill requires the Minister of Justice and the Minister of Health to initiate one or more independent reviews on these three issues no later than 180 days after Bill C-14 receives royal assent (amendment from the House of Commons Standing Committee on Justice and Human Rights) and must report back to Parliament no later than 2 years after the reviews are initiated (amendment from the Senate).

## II. Definitions

Bill C-14 enacts new definitions in the *Criminal Code* for the purpose of the national medical assistance in dying regime. (see Annex 1 for a clause by clause guide to Bill C-14). The new section 241.1 (clause 3 of the Bill) is a central provision of the regime as it defines the umbrella term ''medical assistance in dying'' as encompassing what is commonly called voluntary euthanasia (i.e., the administration by a medical practitioner or nurse practitioner of medication[21] that will cause a person's death at their request) and assisted suicide (i.e., the prescription or provision by a medical practitioner or nurse practitioner of medication that a person could self-administer to cause their own death). It should be noted that, in the case of what is commonly called voluntary euthanasia, the provision of medical assistance in dying would result directly in the patient's death, whereas in the case of assisted suicide, the provision of such assistance would result in the patient obtaining medication that they could choose to use – or not – to end their life. This difference is reflected in the new criminal exemptions, as set out below.

With respect to health care professionals, who are regulated under PT responsibility, the new section 241.1 defines the terms ‘‘medical practitioner’’ and ‘‘pharmacist’’ as those who are entitled to practise medicine or pharmacology under provincial laws (e.g., licensed professionals who are members of provincial colleges of physicians and surgeons or provincial colleges of pharmacists).[22] Although the term “physician” or “doctor” is more plain language in English, the term “medical practitioner” is already used in several places in the *Criminal Code*, and so is adopted to ensure consistency within the *Criminal Code*. The term “nurse practitioner” is defined in the Bill as a registered nurse who is designated as a nurse practitioner or other equivalent title, and who is entitled to autonomously make diagnoses, interpret tests, prescribe medications and treat individuals.

## III. Criminal Exemptions

*Culpable Homicide*

It is a crime to intentionally cause the death of another person, even if they consent to die (section 14 of the *Criminal Code*). The Bill therefore enacts a new exemption from criminal liability for culpable homicide for medical practitioners and nurse practitioners who provide medical assistance in dying in the form of what is commonly called voluntary euthanasia, i.e., the administration of medication to a person, at their request, that causes their death (new section 227(1) of the *Criminal Code*, in clause 2 of the Bill). The Bill also creates an additional and related exemption for any other person who does anything in order to help a physician or nurse practitioner provide such assistance. The latter category includes, for instance, a social worker who is asked to meet with the patient to help assess the voluntariness of their request, a lawyer to a hospital who is asked to review the documents to verify compliance with the law, or a pharmacist who fills the prescription for the medication to be administered by a medical practitioner or nurse practitioner to the patient.

The Bill also re-enacts the legal rule (section 14 of the *Criminal Code* – Clause 1 of the Bill) that says that a person’s consent to die is not a defence for someone who inflicts death on them. This rule was found to be unconstitutional in *Carter*. At the same time, the Bill clarifies that this legal rule does not apply in the case of a person who receives medical assistance in dying in conformity with the new regime (new subsection 227(4) of the *Criminal Code* – Clause 2 of the Bill). In all other circumstances, causing the death of a person who consented to die continues to be a crime.

*Aiding a Person to Die by Suicide*

It is a crime to assist a person to die by suicide, whether or not suicide ensues (paragraph 241(b) of the *Criminal Code*). Assistance can be in the form of providing information about how to end their life, or providing a tool or other means that could be used. The Bill therefore enacts criminal exemptions for the offence of aiding a person to die by suicide for medical practitioners, nurse practitioners and people who would assist them in providing or dispensing medication to eligible persons. The person could self-administer the medication to cause their own death, either at that time or at a later time of their choosing (new subsections 241(2) and 241(3) of the *Criminal Code* – Clause 3 of the Bill).

The Bill recognizes that after a person receives the prescription from the physician or nurse practitioner (which meets the definition of medical assistance in dying in the *Criminal Code* as explained above), they may still need various forms of assistance depending on their state of health. For instance, they may need someone to collect the medication from the pharmacy, to open the bottle that contains such medication, or to lift a glass of water to their mouth so that they can swallow it. As these forms of conduct are prohibited under the offence of aiding a person to die by suicide, additional exemptions are provided in the Bill to address this type of assistance.

Specifically, pharmacists who fill a prescription for the purpose of medical assistance in dying and give the medication directly to the patient or to another person on their behalf, is exempted for this conduct (new subsection 241(4) - clause 3 of the Bill). Similarly, any person who helps the patient to self-administer the medication is also exempted from criminal responsibility (new subsection 241(5) – clause 3 of the Bill). Any person helping someone to self-administer the medication should exercise extreme caution however, as the decision to self-administer, and the final actions of doing so, must be those of the patient for whom the medication was prescribed. In any other circumstance, there would remain a risk of criminal prosecution.

Finally, the Bill re-enacts the offence of aiding a person to die by suicide, and this conduct continues to be criminal in all circumstances other than those described in the medical assistance in dying regime under the *Criminal Code*.

*Clarification regarding the provision of information on medical assistance in dying*

For greater certainty, the Bill clarifies that no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying (provision added by the House of Commons Standing Committee on Justice and Human Rights).

*"Reasonable but mistaken belief"*

For greater certainty, the Bill codifies a common law principle to clarify that the exemptions still apply even if the practitioners, or other exempted individuals, have a reasonable but mistaken belief about some relevant fact; for example, whether the person is 18 years of age and is therefore eligible to receive medical assistance in dying (new subsections clauses 227(3) and 241(6) in clauses 2 and 3 of the Bill). These will essentially function as a "good faith" defence for those who participate in medical assistance in dying.

## IV. Eligibility Criteria for Medical Assistance in Dying

Bill C-14 enacts a new section 241.2 of the *Criminal Code*, which in essence sets out the criminal rules surrounding the provision of medical assistance in dying. New subsections 241.2(1) and 241.2(2) set out the eligibility criteria for such assistance in Canada. Under the new federal legislation, medical assistance in dying is available to a person who meets all of the following criteria (subsection 241.2(1)):

- being an adult (at least 18 years old) who is mentally competent ("capable") to make health care decisions for themselves;
- having a grievous and irremediable medical condition (as defined under subsection 241.2(2));
- making a voluntary request for medical assistance in dying which does not result from external pressure;
- giving informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care; and,
- being eligible for health services funded by a government.

A grievous and irremediable medical condition is expressly defined under the Bill as (subsection 241.2(2)):

- having a serious and incurable illness, disease or disability; and,
- being in an advanced state of irreversible decline in capability; and,
- experiencing enduring physical or psychological suffering, due to the illness, disease, disability or state of decline, that is intolerable to the person and cannot be relieved in a manner that they consider acceptable; and,
- where the person's natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without requiring a specific prognosis as to the length of time the person has left to live.

These eligibility criteria enable individuals who are intolerably suffering, in an advanced state of irreversible decline in capability, and who are on a path towards their natural death, to have the option of a peaceful medically-assisted dying process, instead of having to endure a painful, prolonged or undignified one. It enables them to make a fundamentally personal decision concerning their bodily integrity, autonomy, and dignity, which could also help prevent them from ending their lives prematurely, by providing reassurance that they will have access to medical assistance in dying at a time when they may be unable to end their own life without assistance. Individuals have to be able to provide informed consent when eligibility is assessed and confirm their consent one last time immediately before medical assistance in dying is provided.

In *Carter*, the Court expressly stated that the scope of its declaration was "intended to respond to the factual circumstances" of the case[23] and that it made "no pronouncement on other situations where physician-assisted dying may be sought".[24] The eligibility criteria in Bill C-14 directly responds to the factual circumstances raised in *Carter*. The individuals whose cases were considered by the Court were either in physical decline and nearing death in the late stages of a fatal disease, or were otherwise nearing the end of their lives while in decline due to a condition that was not fatal in itself. This approach is also consistent with the Court's comparison of medical assistance in dying with other forms of end-of-life care,[25] i.e., medical assistance in dying becomes another end-of-life option, in addition to palliative care and palliative sedation for instance, for intolerably suffering individuals whose deaths are reasonably foreseeable. The Court also recognized that assisted dying is a complex issue involving various interests, that a

number of solutions were possible, and that Parliament's response would receive a high degree of deference.[26] (see Annex B for more information)

The criterion of reasonable foreseeability of death is intended to require a temporal but flexible connection between the person's overall medical circumstances and their anticipated death. As some medical conditions may cause individuals to irreversibly decline and suffer for a long period of time before dying, the eligibility criteria do not impose any specific requirements in terms of prognosis or proximity to death (e.g., a six month prognosis as the U.S. states' medical assistance in dying laws require). The medical condition that is causing the intolerable suffering does not need to be the cause of the reasonably foreseeable death either. In other words, eligibility is not limited to those who are dying from a fatal disease. Eligibility needs to be assessed on a case-by-case basis, with flexibility to reflect the uniqueness of each person's circumstances, but with limits that require a natural death to be foreseeable in a period of time that is not too remote. It should be noted that people with a mental illness or physical disability are not excluded from the regime, but will only be able to access medical assistance in dying if they meet all of the eligibility criteria.

The requirement for the person to be eligible to receive publicly funded health services is intended to prevent foreigners from visiting Canada to obtain medical assistance in dying.

## V. Safeguards

In *Carter*, the Court acknowledged that there are inherent risks in permitting medical assistance in dying, but agreed with the trial judge that these risks "can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced".[27] As enacted in other jurisdictions that have medical assistance in dying, robust procedural safeguards are a critical component of any carefully-designed regime and are essential to prevent error and abuse from occurring and to protect vulnerable persons.

Consistent with the Court ruling and the Special Joint Committee's recommendations on safeguards, Bill C-14 enacts mandatory procedural safeguards that medical practitioners and nurse practitioners will be required to follow before providing medical assistance in dying to a person. These safeguards require the medical practitioner or nurse practitioner to:

- confirm that the person meets all eligibility criteria for medical assistance in dying;
- ensure that the person's request was made in writing after the person was informed that he or she has a grievous and irremediable medical condition and be satisfied that it was signed and dated in the presence of two independent witnesses who also signed and dated the request;
- ensure that the person was informed that they may withdraw their request at any time and in any manner;
- ensure that a second independent medical practitioner or nurse practitioner provided a written opinion confirming the person's eligibility;
- ensure that a period of at least 10 clear days has elapsed between the moment the written request was signed and the provision of medical assistance in dying (unless both practitioners agree that death or loss of capacity to consent is imminent);

- immediately before providing such assistance, confirm the person's consent; and,
- if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

In order to be considered independent, the witnesses cannot be beneficiaries under the will of that person or otherwise benefit from their death, or be involved directly in giving care to the person, among other criteria (new subsection 241.2(5) – clause 3 of the Bill). With respect to the independence of the first medical practitioner or nurse practitioner from the second one, the Bill provides that they cannot be connected to each other in any way that could impair their objectivity, such as by being in a mentoring relationship with each other. They also need to be independent of the patient, in the sense that they cannot be beneficiaries under his or her will, or be otherwise connected to them in a manner that could affect their objectivity (new subsection 241.2(6)). However, the legislation makes clear that standard compensation for providing medical services does not affect the physician or nurse practitioner's independence.

The Bill also makes provision for individuals who are unable to sign their own request, by enabling them to ask a capable adult, who is not directly involved in providing health care services to them, to sign and date their request in their presence, on their behalf and under their express direction (new subsection 241.2(4)). The "proxy-signer" must not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death (amendment from the Senate).

In order to fall within the exemption, the medical practitioner or nurse practitioner is also required to act with reasonable knowledge, care and skill, in accordance with applicable provincial laws, rules or standards (new subsection 241.2(7)), and to inform the pharmacist whenever medication is sought or prescribed for the purposes of medical assistance in dying (new subsection 241.2(8)).

Finally, new subsection 241.2(9) clarifies that, for greater certainty, nothing in section 241.2 compels an individual to provide or assist in providing medical assistance in dying. This subsection was added by the House of Commons Standing Committee on Justice and Human Rights at the same time as the amendment to the preamble to recognize that everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms* and that nothing in the Bill affects those freedoms. Both amendements aim to reinforce that nothing in Bill C-14 compels anyone to act against their deeply held beliefs.

## VI. Monitoring System

As recognized by the Court in *Carter*, by the Special Joint Committee's report, as well as by many stakeholders, a pan-Canadian monitoring system to collect and analyze data on the provision of medical assistance in dying across Canada, to monitor trends and provide information to the public on the implementation of the new law, is a critical component of the new Canadian regime. Such a monitoring system is essential to foster transparency and public trust in the system.

*Regulation-making Power*

Bill C-14 requires the Minister of Health to make regulations that she considers necessary to establish a system for monitoring requests for, and the provision of, medical assistance in dying in Canada. Such regulations may include: information to be provided by medical practitioners, nurse practitioners or pharmacists to a designated body; the form, manner and time in which the information must be provided; the collection of information from coroners and medical examiners; details about how the data would be analyzed, interpreted, and reported to the public; and rules for the protection and disposal of such information (new subsection 241.31(3) – clause 4 of the Bill). Subsection 241.31(3.1) was also added by the House of Commons Standing Committee on Justice and Human Rights to require the Minister of Health, in cooperation with provinces and territories, to establish guidelines on information to be included on death certificates, including how to identify medical assistance in dying as the manner of death, as well as the underlying illness, disease or disability.

*Filing Obligations and Related Offences*

To enable the monitoring regime to operate effectively, Bill C-14 also creates a legal obligation for medical and nurse practitioners who receive a written request for medical assistance in dying to provide information as prescribed in regulations (new subsection 241.31(1)). Pharmacists are also required to provide information in relation to their provision of medications used for such assistance (new subsection 241.31(2)). Bill C-14 enacts a hybrid offence – punishable by a maximum of 2 years imprisonment – for failure to comply with the reporting obligations, and for any person who knowingly breaches the regulations. The reporting obligations and related offences will be brought into force at a later date than the rest of the Bill, once the detailed regulations on the monitoring regime are in place.

*Coming into force*

The provision requiring the making of regulations on monitoring, and the associated legal obligations of medical practitioners, nurse practitioners and pharmacists to provide information in accordance with the regulations, will come into force no later than 12 months after royal assent.

## VII. Other Offences

To ensure compliance with the new medical assistance in dying legislation, and given the serious and irrevocable nature of helping people die and the potential for criminal liability for medical professionals, the Bill enacts new hybrid offences for failure to comply with the mandatory safeguards (new section 241.3), and for forging or destroying documents related to assistance requests with criminal intent (new section 241.4). For instance, a person might destroy a written medical assistance in dying request in order to block someone's access to such assistance or to interfere with a medical practitioner's ability to rely on an exemption, or they might forge the signature of a person they were trying to influence to seek assistance. These offences are punishable by a maximum term of imprisonment of five years, where prosecuted on indictment, and to a maximum term of 18 months on summary conviction.

### VIII. Related Amendments

Bill C-14 enacts related amendments to other statutes to ensure that recourse to medical assistance in dying does not affect pensions under the *Pension Act* or benefits under the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*. It also amends the *Corrections and Conditional Release Act* to ensure that no investigation need be conducted under section 19 of that *Act* as a result of a person dying with medical assistance.

### IX. Parliamentary Review

The Bill includes a mandatory legislative review to take place five years after its coming into force. The medical assistance in dying legislation will be referred to a designated parliamentary committee of the House of Commons, the Senate or both Houses of Parliament. The committee will be mandated to review all provisions of Bill C-14, as well as the state of palliative care in Canada, and submit a report to Parliament including a statement setting out any changes to the provisions that the committee recommends. It could also consider any reports that would be published under the monitoring regime. The parliamentary review could assess whether the new regime is meeting its legislatives objectives, how medical assistance in dying is being implemented across Canada, and identify areas of potential changes and improvements, if necessary.

### X. Areas for Further Study

Clause 9.1 was added to Bill C-14 in order to create a statutory obligation on the Ministers of Justice and Health to initiate, no later than 180 days after the day on which this Act receives royal assent, one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition (amendment from the House of Commons Standing Committee on Justice and Human Rights). The Ministers of Justice and Health must report back to Parliament on these independent studies no later than 2 years after the reviews are initiated (amendment from the Senate).

## Part 2 – Consideration of International Medical Assistance in Dying Regimes

Canada is not alone in establishing a legislative regime that includes exemptions from criminal law to allow medical assistance in dying. In addition to being informed by the *Carter* ruling and the many public consultation exercises that have taken place across Canada over the past year, Bill C-14 is informed by the laws relating to medical assistance in dying in other jurisdictions, as well as research on how those regimes work in practice,[28] much of which was also before the courts in the *Carter* case. (see Annex C for more information).

### I. Foreign Laws Overview

At present, in addition to Québec, there are 8 jurisdictions with precise legal rules for the provision of medical assistance in dying: 4 US states (Oregon, Washington, Vermont and

California), the country of Colombia,[29] and the European countries of Belgium, the Netherlands, and Luxembourg (often referred to as the "Benelux" countries). The laws (or ministerial resolution in the case of Colombia) share many similarities, in particular with respect to the safeguards, such as the requirements for a second opinion and a voluntary request by the patient that must be in writing, which almost all regimes require. Many regimes also require the written requests to be witnessed, and require wait periods between the request and the provision of medical assistance in dying (or at least require the physician to talk to the patient over a period of time to ensure the suffering is enduring and the decision is firm). Colombia has a process involving an interdisciplinary committee within each hospital that is tasked with assessing the request and supporting the person and their family through the process. Almost all regimes also have mandatory oversight systems involving monitoring and publicly reporting on how assistance is being provided. In Switzerland, although it is not a crime to assist someone to die by suicide for unselfish motives, there is no law regulating how and to whom the assistance can be provided or what types of safeguards are required.

The foreign laws take differing approaches with respect to eligibility such as: the types of medical circumstances that can enable a person to receive medical assistance in dying; whether assistance is available to adults only or also to minors; and whether a person can receive medical assistance in dying after they have lost the ability to express their wishes, based on a request made while they were competent (i.e., advance requests). The foreign laws also differ with respect to the form of medical assistance in dying that is permitted, i.e., whether the medication can be administered by the physician or whether the person must take the action that causes their own death by self-administering it. Some of these differences will be described below.

## II. U.S. State Laws

The first place to enact legislation permitting medical assistance in dying was the US state of Oregon, which adopted the *Death with Dignity Act* in 1994.[30] The Oregon legislation permits a mentally competent adult (18 years or older) to obtain the assistance of a physician to die if they make a voluntary request and they suffer from a "terminal disease," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[31] There is no requirement for the person to be suffering intolerably.

The physician is only permitted to provide the person with a prescription for medication that could end their life (physician-assisted suicide). The *Act* expressly states that it does not allow physicians to end a person's life by "active euthanasia."[32] There is no possibility of advance requests that would be put into effect if the person loses their competence.

Data from Oregon indicates:[33]

- From 1997 to 2014, 1,327 individuals received prescriptions for medication and one-in-three prescriptions (468) did not result in death from such medication;
- Physician-assisted suicide increased from 0.5 deaths per 100,000 population in 1998, to 2.6 deaths in 2014;
- The most common underlying illnesses are: cancer (69%), amyotrophic lateral sclerosis (ALS) (16%), chronic lower respiratory disease (4%) and heart disease (3%);

- The most important end-of-life concerns for these individuals were losing autonomy (91%), less able to engage in activities making life enjoyable (87%); and loss of dignity (71%).[34]

The Oregon law has served as a model for 3 other US states that have adopted laws: Washington (2008), Vermont (2013) and California (2015). All provide eligibility only to adults who are terminally ill, in the sense of having a disease that is expected to cause their death within 6 months, and only permit the physician to provide medication that the person must self-administer. Numerous similar bills are currently before other state legislatures. (see Annex D)

*Considerations for Canada*

The US state laws, and the reports provided by the bodies tasked with monitoring them, have all been reviewed in the development of the Canadian legislation. In terms of eligibility, the legal approaches contain no mandatory requirement for the person to be suffering unbearably or intolerably from their condition or to be in an advanced state of decline. In other respects, however, they are fairly restrictive in permitting medical assistance in dying only to people who have a fatal disease and who are expected to die within six months.

While the US state approach may accommodate individuals suffering from certain diseases that lead to a steady, rapid and predictable decline toward death, it may fail to accommodate other types of conditions. For example, some degenerative diseases can progress more unpredictably and over a longer period of time, such that it can be more difficult to foresee when death will occur and suffering associated with the dying process can last longer. The US state approach also does not provide medical assistance in dying as an end-of-life option to intolerably suffering individuals who are not dying from a fatal disease, but who are nonetheless approaching death for other reasons.

Finally, as the US state approach only permits physicians to prescribe medication for the person to self-administer, it would not accommodate those who are physically unable to self-administer, leaving them unable to access a peaceful and pain-free medically assisted death.

## III. Colombia

In response to two rulings[35] from the Constitutional Court of Colombia, the Ministry of Health and Social Protection in Colombia adopted Resolution 1216 of 2015[36] in April 2015 which establishes detailed rules and procedures for individuals who wish to access medical assistance in dying. Similar to the US state laws, eligibility is limited to adults who meet the definition of a "terminal patient", which is defined as any person who has a serious condition or pathology that is progressive and irreversible with a prognosis of approaching death or death within a relatively short timeframe. While the resolution does not require that the person have less than 6 months to live, it does contemplate those who are dying in the short term.

Unlike the US state laws, a terminal patient in Colombia can only obtain what is commonly called voluntary euthanasia, i.e., where a physician directly administers the medication to cause the person's death. Also different from the US state approach, Colombia does permit a patient to

prepare an advance request in case they become no longer capable of expressing their wishes in the future.

*Considerations for Canada*

Like the US state laws, the Colombian approach appears somewhat limited by virtue of the requirement that death be expected within a relatively short time frame. The language of "terminal patient" also suggests, although it is not entirely clear, that the patient must be dying from the illness that is progressive and irreversible, which would also deny access to those who may be approaching death but whose suffering stems from non-fatal conditions. As the Resolution was adopted in 2015, there is as yet no publicly available data on the experience with medical assistance in dying in Colombia.

## IV. Belgium, the Netherlands and Luxembourg (the "Benelux" countries)

Both the Netherlands and Belgium enacted legislation in 2002,[37] although courts in the Netherlands had over several decades developed criteria for physicians to perform what is commonly called voluntary euthanasia without criminal consequences. Luxembourg enacted its law in 2009.[38]

*Medical eligibility*

Regarding eligibility, the three Benelux laws are very similar: people are eligible if they have "intolerable" or "unbearable" suffering, either physical or psychological, resulting from a serious and incurable medical condition, and where there is no prospect of improvement. They can be eligible even if they are not dying or suffering from a condition that is life-threatening. As a result, people have obtained assistance to die in the Benelux countries where they suffer only from mental illness, from a physical disability, or other medical conditions that do not shorten life.

Some cases from Belgium and the Netherlands involving patients who were not nearing death have received significant international media attention, for example: a transgendered person suffering psychologically after a failed sex change surgery; middle-aged and deaf twins who were also going blind; an anorexic woman who was a survivor of sexual abuse; individuals suffering from grief at the loss of loved ones.[39]

Data collected in these jurisdictions indicate some changing trends. While cancer is still the main underlying illness for medical assistance in dying requests, its proportion has decreased significantly in recent years, while the proportion of mental illness cases has increased. For example, in Belgium, cancer represented 83% of all medical assistance in dying performed in 2003 compared to 69% in 2013, while mental illness cases increased from zero in 2003 to 4% in 2013 of all medical assistance in dying reported.[40] Similarly, in the Netherlands, cancer represented 88% of all medical assistance in dying performed in 2003 compared to 74% in 2013. Data on mental illness in the Netherlands has been reported starting in 2012 only, but has shown a consistent and significant yearly increase from 14 cases in 2012 to 41 cases in 2014.[41]

*Minors*

In Luxembourg, medical assistance in dying is available only to adults. In the Netherlands, minors as young as 12 can request medical assistance in dying with their parents' consent, and minors aged 16 and 17 can request such assistance as long as their parents have been consulted. Belgian law provides access to adults and "emancipated minors"[42] equally. Amendments to Belgian law in 2014 extended eligibility to all minors, but on narrower grounds of eligibility than exist for adults and emancipated minors: they must be in constant and unbearable physical (but not psychological) pain, and they must be likely to die in the short term. Parental consent and other additional safeguards are also required in these circumstances.

*Advance requests in case of loss of competence*

All three Benelux laws permit individuals to make an advance request for medical assistance in dying that could be carried out in case they lose their ability to express their wishes. In Belgium and Luxembourg, the request can only be carried out where the person is "in a state of irreversible unconsciousness", e.g., in a coma. Only in the Netherlands are advance requests permitted where the person is unable to express their wishes but is nonetheless conscious, such as persons with dementia or Alzheimer's.

*Considerations for Canada*

The Benelux laws were studied closely, in particular their approach to eligibility. While some recommended this approach for Canada, others expressed concern about it. Accordingly, the Government has committed to study additional complex circumstances in which a person may seek access to medical assistance in dying, namely requests by mature minors, advance requests, and requests for assistance where mental illness is the sole underlying medical condition.

All regimes worldwide, except for those in Belgium and the Netherlands, limit access to adults. The 2014 extension of eligibility to children in Belgium was controversial, including in Belgium, and drew international media attention. The trial judge in *Carter* heard a significant amount of evidence on views about medical assistance in dying in Canada and found that there was a strong consensus that if it were ever to be ethical, it would only be with respect to a "competent, informed, voluntary *adult* patient who is grievously ill and suffering from symptoms that cannot be alleviated."[43] There was no evidence before the courts in *Carter* concerning the development of the brain and mental capacity of minors to understand the consequences and seriousness of such a decision, nor is there at present any available information about the willingness of Canadian physicians to provide medical assistance in dying to minors. The Canadian Paediatric Society, in their submission to the Special Joint Committee, recommended against including access for minors at this time, and submitted that comprehensive consultations should be undertaken before moving in this direction.[44]

With respect to advance requests for medical assistance in dying that would be carried out after the patient has lost the ability to express their wishes, evidence from the Netherlands suggests that in the case of individuals suffering from dementia, physicians are generally unwilling to administer medical assistance in dying after the patient has lost the ability to express their

wishes.[45] This evidence raises questions about the prospect of permitting a practice that Canadian physicians and nurse practitioners might be unwilling to honour. In its testimony before the Special Joint Committee, the Alzheimer's Society of Canada noted that the disease has become a special focus in the debate about physician-assisted dying, but it nonetheless warned of the risks associated with permitting medical assistance in dying for individuals who have lost the ability to express their wishes. For instance, they indicated that the nature of the disease makes it "difficult or impossible to know what the person with dementia comes to value over time, especially if those values are at odds with previously expressed desires" and that the "risks are just too great" to allow such assistance when a person is no longer competent to express their wishes.[46] Other evidence supports the view that people generally make poor predictions about how they will cope with negative events in the future, and that in fact people cope much better than they anticipate.[47]

There has also been significant discussion regarding eligibility for individuals who suffer unbearably only from mental illness. In the Benelux countries, the only places where medical assistance in dying in these circumstances is legal, this remains controversial. Recently, a group of 65 professors, psychiatrists, and psychologists in Belgium wrote an open letter "about the increasing trivializing of euthanasia on the ground of psychological suffering only" and urging the law to be amended to exclude medical assistance in dying in these circumstances.[48] A recent study of assistance in dying for individuals with mental illness in the Netherlands found that in more than half of approved cases, people declined treatment that could have helped, that many cited loneliness as an important reason for wanting to die, and that people often sought help to die from doctors they had not seen before.[49]

Broad eligibility for medical assistance in dying could pose real risks for individuals who are marginalized, lonely, or lacking in necessary social or other supports, and it could re-enforce negative social perceptions about the quality of life of people who are ill or disabled. For instance, as one witness wrote in a submission to the Special Joint Committee: "Having to wear diapers and drooling are highly stigmatized departures from what is expected of adult bodies. Those of us who deviate from these norms experience social shame and stigma that erodes resilience and increases vulnerability. The more deeply these stigmatized accounts are embedded in our discourse and social policy, the more deeply virulent social prejudice takes hold within our culture."[50]

## Part 3 – Relation to Quebec's Law

The National Assembly of Quebec passed Bill 52, an *Act respecting end-of-life care*, on June 5, 2014. The *Act* came into force 18 months later, on December 10, 2015. The legislation was the end result of a significant amount of study, consultation and deliberation that commenced with the creation of the *Select Committee on Dying with Dignity* in late 2009. The Committee's work lasted for two years, and involved:

- hearings with 32 experts (February/March 2010);
- the release of a public consultation paper in May 2010 (6,558 responses and 273 briefs were received between May 2010 and July 2011);

- public hearings (239 individuals and groups over 29 days in 8 cities from September 2010 to March 2011);
- 21 meetings with experts in Europe (in June 2011); and,
- committee deliberations over 51 meetings (from June 2011 to March 2012).[51]

The Committee tabled its report in March 2012, recommending that a new form of care, to be called "medical aid in dying", be "part of the end of life continuum of care".[52] They further described specific criteria that should be met, and that these "be clear and specific so as to facilitate assessment, but general enough to allow doctors to use their professional judgment in each case."[53]

Specifically, and in addition to criteria requiring that the patient be at "end of life" and suffering unbearably, they recommended that the patient be "in an advanced state of weakening capacities, with no chance of improvement". Justice Smith of the Supreme Court of British Columbia, who presided over the *Carter* case at trial, expressly adopted this criterion, referencing the Select Committee's report, when she ruled that "the reference to 'grievously and irremediably ill persons' should be limited to those who are also in an advanced state of weakening capacities, with no chance of improvement."[54] The Select Committee's recommendations were ultimately adopted into Bill 52, which was introduced in the National Assembly in June 2013, and was adopted in June 2014.

In general, the eligibility criteria in the *Criminal Code* are similar to those under Quebec's *An Act Respecting End-of-Life Care.*[55] On the one hand, the criminal legislation is intended to be broader in terms of the temporal connection between the person's medical condition and the anticipated timing of their deaths; Quebec's law requires that the patient be "at the end of life", whereas the criminal legislation uses the term "death has become reasonably foreseeable", which is a more familiar legal concept, and possibly more flexible, in that it does not require a specific prognosis as to the length of time that the person has left to live. On the other hand, the Quebec legislation does not expressly require that the unbearable suffering be caused by the person's medical condition, whereas the criminal legislation does. It should also be noted that the *Criminal Code* amendments allow both assisted suicide and what is commonly called voluntary euthanasia, while Quebec's law only permits the latter.

## Part 4 – Statement of Potential *Charter* Impacts

The Minister of Justice has reviewed this Bill for compliance with the Constitution, including the *Charter* in accordance with her obligations under section 4.1 of the *Department of Justice Act*. This review included consideration of, amongst other things, the objectives and features of the Bill as described above in Part 1, the social science evidence and legislative, governmental and consultative reports referred to in Part 1, the evidence of other jurisdictions' approaches to and experiences with medical assistance in dying discussed in Parts 2 and 3, and the views and findings of the courts in *Carter*, including the Supreme Court of Canada.

The following non-exhaustive list of potential impacts on the rights and freedoms guaranteed by the *Charter* is presented to assist in informing the public and Parliamentary debate, and consequently to better enable the dialogue between Parliament and the courts. In addition, the

Minister of Justice tabled an Addendum to this Legislative Background in the House of Commons and published it on the Department of Justice website. This Part of the Legislative Background should therefore be read together with the Addendum, which provides an explanation of the government's position on the constitutionality of the new legislation, as well as the rationale for the approach in Bill C-14.

*Restricted to Individuals whose Deaths have become Reasonably Foreseeable*

Restricting access only to persons whose deaths are reasonably foreseeable has the potential to impact:

- section 7 of the *Charter*, which protects against deprivations of life, liberty or security of the person that do not accord with the principles of fundamental justice, and;
- subsection 15(1) of the *Charter*, which protects against discrimination on numerous grounds, including disability.

The rights to liberty and security of the person could be impacted by depriving persons suffering intolerably of lawful assistance to end their lives. This could impact the section 7 *Charter* rights of those who are suffering intolerably as a result of a serious and incurable condition, but whose natural death is not reasonably foreseeable. This could include individuals suffering only from a mental illness, and individuals with physical disabilities who lack the physical capacity to end their own lives. Persons with mental illness or disabilities would only have access to medical assistance in dying if they meet all of the eligibility criteria.

The right to equality could also be impacted if restricting access to end-of-life situations is viewed as treating people differently on the basis of their distinct disabilities, diseases or illnesses. For example, a person who is suffering intolerably from a particular disease that does not make death reasonably foreseeable, will be treated differently in terms of access from persons whose intolerable suffering derives from a different disease that does make death reasonably foreseeable. The restriction may also be viewed as treating people whose disabilities may make it effectively impossible to die by suicide without assistance differently from individuals who are able to take their own lives without the criminal law standing in the way.

*Rationale*: Restricting access to only those individuals whose death is reasonably foreseeable allows them to choose a peaceful, medically assisted death where their medical circumstances are such that the dying process would otherwise be painful, distressing, frightening, prolonged or otherwise lacking dignity from their perspective. This approach respects autonomy during the passage to death, while otherwise prioritizing respect for human life and the equality of all people regardless of illness, disability or age. It also furthers the objective of suicide prevention and the protection of the vulnerable. Recognizing the complexity of the legal and social issues associated with medical assistance in dying, this approach strikes an appropriate balance between the competing rights, interests and values. This last consideration also applies to the other potential impacts discussed below.

*Restricted to "Competent" Adults (no advance directives)*

Restricting access to competent adults precludes the possibility of a person arranging medical assistance in dying by advance directive, which could impact the section 7 rights to life, liberty, and security of the person, and the subsection 15(1) right to equality.

Section 7 could be impacted because persons dealing with the prospect of intolerable suffering could be faced with the choice of ending their lives earlier than they would otherwise want (by suicide or potentially by seeking medical assistance in dying) or risk permanently losing access to medical assistance in dying once they no longer have capacity.

Equality rights under subsection15(1) could also be impacted because persons whose disability, disease or illness cause them intolerable suffering and deprive them of the capacity to consent would not be able to access medical assistance in dying in the same circumstances as those whose disability, disease or illness do not deprive them of that capacity.

*Rationale*: Advance directives generally do not provide reliable evidence of a person's consent at the time that medical assistance in dying would be provided. The requirement that a person be capable of consent at the time of the request for assistance provides better protection for vulnerable individuals, in particular when their present state of mind and/or suffering cannot be conclusively determined. It also guards against the effects of inaccurate assumptions about the quality and value of life in certain circumstances.

*Restricted to Adults (excludes mature minors)*

Restricting access to adults (at least 18 years old) could impact the rights of "mature minors", in particular their section 7 rights to life, liberty and security of the person, and their subsection 15(1) right not to be discriminated against based on age. Mature minors are recognized as having the right to a degree of autonomy in relation to their medical treatment in some circumstances.

*Rationale*: Limiting access to adults serves to protect children, who are particularly vulnerable both by virtue of their age and their disability, disease or illness. Establishing a clear age cut-off in relation to access to medical assistance in dying, rather than adopting an approach based on an individualized assessment of maturity as is done in relation to decisions to refuse medical treatment, is justified in light of the unique interests at stake. Respecting a mature minor's refusal of further unwanted medical treatment is not the same as acquiescing to a request for active measures to cause death. Acknowledging that further study will be undertaken on potential access to medical assistance in dying for mature minors, including on the need for and adequacy of additional safeguards to protect mature minors if they were to have access to such assistance, the Bill appropriately balances the various important interests.

*Sufficiency of Safeguards to Protect the Vulnerable*

If the safeguards are inadequate to prevent abuse or error, it could impact the section 7 rights to life or security of the person of vulnerable persons. It could be that section 7 obliges Parliament to maintain effective criminal prohibitions against the intentional taking of life, and in this

context to implement robust safeguards to prevent against abuse and error. This would be a novel claim under section 7.

*Rationale*: Parliament's duty to maintain effective criminal prohibitions against the intentional taking of life is inherent in its role as lawmaker. The Bill strikes an appropriate balance between protecting the vulnerable, and ensuring accessibility to those qualified individuals who want medical assistance in dying. The most vulnerable are excluded from accessing medical assistance in dying, while proper safeguards aim to ensure only those qualified persons who consent will receive medical assistance in dying.

*Healthcare Providers' Freedom of Conscience*

The decriminalization of medical assistance in dying will lead to requests to healthcare providers to provide assistance that would be contrary to some healthcare providers' conscience or religious beliefs. Freedom of conscience and religion are protected from government interference by paragraph 2(a) of the *Charter*. Nothing in the Bill compels healthcare providers to provide such assistance or could otherwise impact their paragraph 2(a) rights.

*Excessive Burden of Safeguards unduly Limiting Access*

If the safeguards are so burdensome as to unduly limit access to medical assistance in dying to those who qualify, it could impact their section 7 rights to life, liberty or security of the person.

*Rationale*: The Bill strikes an appropriate balance between protecting the vulnerable, and ensuring accessibility to those qualified individuals who want medical assistance in dying. The safeguards are reasonable and appropriate to ensure that individuals meet the criteria for eligibility, and most importantly to validate their intent and consent.

*Witness Requirements*

The requirement that individuals seeking medical assistance in dying have two witnesses to their signed, written request, could impact the right to privacy protected by section 8 of the *Charter*. In some circumstances, individuals may be obliged by this requirement to disclose their intention to end their lives to individuals in whom they would otherwise not confide.

*Rationale*: In light of the very important interests at stake, a requirement that an individual seeking medical assistance in dying have their signed consent for such assistance witnessed by two independent individuals is reasonable in the circumstances, even when the fulfilment of that requirement may incidentally compel the disclosure of private information. Such a requirement is also consistent with Canadian legal practices and traditions when signing legal documents of significance.

[1] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 [*Carter*].
[2] *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519.
[3] *Carter*, supra note 1 at para 127.
[4] *Carter*, *supra* note 1 at para 83.
[5] *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para 120, [2013] 3 SCR 1101; *Carter, supra* note 1 at para 89.
[6] *Carter*, *supra* note 1 at para 86.
[7] *Ibid* at para 127.
[8] *Ibid*.
[9] Although there were several plaintiffs in the case, Gloria Taylor was the only claimant before the Court who was seeking access to medical assistance in dying. The circumstances of Kay Carter were also considered by the Court, as Mrs. Carter's daughter Lee as well as her son-in-law were also plaintiffs in the case.
[10] *Carter*, supra note 1 at para 111.
[11] *Ibid* at paras 95, 98.
[12] *Ibid* at paras 97-98.
[13] In its January 15, 2016 decision, the Supreme Court of Canada also exempted Quebec from the four-month extension and granted an exemption to those who wish to access their rights so that they may apply to the superior court of their jurisdiction for relief in accordance with the criteria set out in paragraph 127 of the *Carter* ruling.
[14] *Carter v Canada* (Attorney General), 2012 BCSC 886 [*Carter* 2012]; *Carter v Canada*, 2013 BCCA 435; *Carter*, *supra* note 1; see also Annex E: Bibliography on Medical Assistance in Dying.
[15] See Annex E: Bibliography on Medical Assistance in Dying.
[16] House of Commons and Senate, Sepcial Joint Committee on Physician-Assited Dying, *Medical Assistance in Dying: A Patient-Centered Approach* (February 2016) (Joint Chairs: Hon. Kelvin Kenneth Ogilvie & Robert Oliphant), online: <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=8120006&Language=E&Mode=1&Parl=42&Ses=1>.
[17] External Panel on Options for a Legislative Response to *Carter v. Canada*, *Consultation on Physician-Assisted Dying – Summary of Results and Key Findings*: Final Report (December 15, 2015), online: <http://www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/index.html>.
[18] *Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying,* Final Report (November 30, 2015) (Co Chair: Jenifer Gibson & Maureen Taylor), online: <http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf>.
[19] Canadian Medical Association, *A Canadian Approach to Assisted Dying: CMA Member Dialogue*: *Summary Report* (July 2014), online: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/Canadian-Approach-Assisted-Dying-e.pdf>; Canadian Medical Association, *End-of-Life Care – A National Dialogue*: *CMA Member Consultation Report* (July 2014), online: <https://www.cma.ca/Assets/assets-library/document/en/advocacy/end-of-life-care-report-e.pdf>.
[20] The College of Family Physicians of Canada, *A Guide for Reflection on Ethical Issues Concerning Assisted Suicide and Voluntary Euthanasia* (September 2015) (CFPC Task Force on End-of-Life Care), online: <http://www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/Guidefor%20Euthanasia_EN_FInal.pdf>.
[21] In the amendments to the *Criminal Code* in Bill C-14, the term "substance" is used to refer to the medication that would be provided or administered for the purpose of medical assistance in dying.
[22] Under section 35 of the federal *Interpretation Act (R.S.C., 1985, c. I-21)*, the territories are included in the definition of a "province" and so are not expressly mentioned in the amendments to the *Criminal Code*.
[23] *Carter*, supra note 1 at para 127.
[24] *Ibid.*
[25] *Ibid* at paras 66, 115.
[26] *Ibid* at paras 2, 98, 125.
[27] *Ibid* at paras 105, 117.
[28] See Annex E: Bibliography on Medical Assistance in Dying.

[29] In 2015, the Government of Colombia published Resolution 1216 of 2015, which provides a detailed federal policy guiding the practice of euthanasia, which although not a "law", legally-speaking, is law-like in its detailed process and definitions, especially as compared to, for example, the practice of assisted suicide in Switzerland, which is not subject to any specific laws. See Republic of Columbia, Ministry of Health and Social Protection (20 April 2015), online: <https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%201216%20de%202015.pdf> [Columbia "Resolution 1216 of 2015"].

[30] Ballot Measure 16 passed with the support of 51.3% of votes cast. An injunction delayed the coming into force of the legislation until 1997.

[31] US, ORS 127.800-897, *Death with Dignity Act*, Ore, 1997, § 1.01.

[32] *Ibid* at §3.14.

[33] Oregon Public Health Division, Death with Dignity Annual Reports, *Oregon's Death with Dignity Act -- 2014* (February 12, 2015), online: <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>; Portland State University, College of Urban and Public Affairs, *Certified Population Estimates 2014* (December 2014), online: <http://www.pdx.edu/prc/population-reports-estimates>; Portland State University, College of Urban and Public Affairs, *2013 Annual Population Report Tables* (April 2014), online: <http://www.pdx.edu/prc/population-reports-estimates>.

[34] *Ibid.* Other concerns expressed included: losing control of bodily functions (50%); burden on family, friends and caregivers (40%); inadequate pain control or concern about it (31%).

[35] Corte Constitucional de Colombia [Consitutional Court of Colombia], Bogotà, Ruling T-970 of 2014 (which re-affirmed a previous decision from the same court in 1997, Ruling C-239-97), online : <http://www.corteconstitucional.gov.co/relatoria/2014/t-970-14.htm>.

[36] Columbia "Resolution 1216 of 2015", *supra* note 29.

[37] *Belgian Act on Euthanasia of May 28, 2002,* online: <http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59>. *Termination of Life on Request and Assisted Suicide (Review Procedures) Act,* 1 April 2002, online : <http://www.eutanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf>.

[38] *Loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide*, JO, 16 March 2009, 615, online: <http://www.legilux.public.lu/leg/a/archives/2009/0046/a046.pdf> .

[39] Bruno Waterfield, "Belgian killed by euthanasia after a botched sex change operation", *The Telegraph* (1 October 2013), online: <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html>; Karin Wells, "Death of twin brothers fuels debate over Belgian euthanasia law", *CBC News* (5 May 2016), online: <http://www.cbc.ca/news/world/death-of-twin-brothers-fuels-debate-over-belgian-euthanasia-law-1.1334860>; Graeme Hamilton, "*Death by doctor: Controversial physician has made his name delivering euthanasia when no one else will", National Post* (22 November 2013), online: <http://news.nationalpost.com/news/canada/death-by-doctor-controversial-physician-has-made-his-name-delivering-euthanasia-when-no-one-else-will>; Rachel Eddie & Emily Crane, "*Elderly woman, 85, reveals how she decided on euthanasia five minutes after her daughter died as documentary follows her journey to death*", *Daily Mail Australia* (15 September 2015), online: <http://www.dailymail.co.uk/news/article-3234917/Elderly-woman-85-reveals-decided-euthanasia-five-minutes-daughter-died-documentary-follows-journey-death.html>.

[40]Belgique, Commission fédérale de contrôle et d'évaluation de l'euthanasie [Commission fédérale], *Sixième rapport aux chambres législatives*, (2012-2013), online: <http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/19097638_fr.pdf>; Belgique, Commission fédérale, *Cinquième rapport aux Chambres législatives*, (2010-2011), online: <http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/19078961_fr.pdf>; Belgique, Commission fédérale, *Quatrième rapport aux chambres législatives*, (2008-2009), online: <http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/19063733_fr.pdf>; Belgique, Commission fédérale, *Troisième rapport aux chambres législatives*, (2006-2007), online:

<http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/14280500_fr.pdf)>; Belgique, Commission fédérale, *Deuxième rapport aux chambres législatives*, (2004-2005), online: <http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/14088500_fr.pdf>; Belgique, Commission fédérale, *Premier rapport aux chambres législatives*, (2002-2003), online: <http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/federale_controle_en_evaluatiecommissie_euthanasie-fr/14276508_fr.pdf>.

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[42] In Belgium, minors who are 15 years of age or older can file an application for emancipation before a juvenile court which, if granted, will give them almost all the rights of an adult. The emancipation of a minor is considered an exceptional measure and is rarely granted. However, minors are automatically emancipated if they get married.

[43] *Carter* 2012, *supra* note 14 at para 358.

[44] Canadian Paediatric Society, Oral Evidence before the Special Joint Committee on Physician-Assisted Dying (February 2016) at 1820, online: <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8084555>.

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[46] Alzheimer Society of Canada, Oral Evidence before the Special Joint Committee on Physician-Assisted Dying (February 2016) at 1225, online: <http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8079674>.

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[49] Scott Y H Kim, Raymond G De Vries, & John R Peteet, "Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014" (2016) Jama Psychiatry, DOI <10.1001/jamapsychiatry.2015.2887>.

[50] Catherine Frazee, "Submission to the Special Joint Committee on Physician-Assisted Dying" (February 2016) 6, online: <http://www.parl.gc.ca/Content/HOC/Committee/421/PDAM/Brief/BR8103887/br-external/2016-02-12_brief_Catherine_Frazee_e-e.pdf>.

[51] Quebec National Assembly, Select Committee on Dying with Dignity, Dying with Dignity Report (March 2012) (Chair: Maryse Gaudreault), online: http://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_34839en&process=Default&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz .

[52] *Ibid*.

[53] *Ibid* at 80.

[54] *Carter* 2012, *supra* note 14 at paras 867, 1391.

[55] Bill 52, *An Act Respecting End-of-Life Care*, 1st Sess, 14th Leg, Quebec, 2013 (assented to June 10, 2014), RSQ c S-32.0001, s 26.

# Annex A: Clause by Clause Guide to Bill C-14

*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*

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| **Preamble – describes legislative objectives of the Bill** | |
| **Clause 1 of the Bill** | |
| Section 14 of the *Criminal Code* is re-enacted<br><br>*Section 14 was found unconstitutional by the Supreme Court in Carter* | Section 14 specifies that no person may consent to death and any person who inflicts death on another is criminally responsible regardless of whether they consented to die<br><br>In new subsection 227(4) of the *Criminal Code* (clause 2 of the Bill), it is made clear that the rule in section 14 does not apply where medical assistance in dying is provided in accordance with the criminal law regime |
| **Clause 2 of the Bill** | |
| New section 227 of the *Criminal Code* is enacted | Exemptions for medical practitioners and nurse practitioners and others who assist them, from culpable homicide, where they provide or assist in the provision of medical assistance in dying in the form of administration of medication to a person, at their request, that causes their death<br><br>Includes a cross-reference to definitions found in new section 241.1 (clause 3) |
| **Clause 3 of the Bill** | |
| Paragraph 241(1)(b) of the *Criminal Code* is re-enacted<br><br>*Paragraph 241(b) was found unconstitutional by the Supreme Court in Carter* | Paragraph 241(1)(b) makes it an offence for any person to "aid a person" to die by suicide |
| New subsections 241(2) – (7) are enacted | Exemptions for medical practitioners and nurse practitioners and others who assist, from aiding a person to die by suicide, where such assistance is in the form of providing or prescribing medication to a person, at their request, that the person could self-administer to cause their own death<br><br>Includes exemptions for pharmacists who fill prescriptions in relation to medical assistance in dying, and for any person who aids the person to self-administer the medication, and clarifies that no social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying<br><br>Cross-reference to definitions found in new section 241.1 (clause 3) |
| New section 241.1 is enacted | Provides definitions for the terms used in the lawful medical assistance in dying regime (*medical assistance in dying; medical practitioner; nurse practitioner; pharmacist*) |
| New section 241.2 is enacted | Requirements for lawful provision of medical assistance in dying:<br>• eligibility criteria including definition of "grievous and irremediable medical condition"<br>• mandatory procedural safeguards<br>• meaning of "independence" in relation to witnesses and physicians and nurse practitioners |

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| | • requirement for reasonable care and skill, compliance with applicable PT rules and duty to inform pharmacist that medication is prescribed or obtained for medical assistance in dying<br>• clarification that nothing in this section compels an individual to provide or assist in providing medical assistance in dying |
| New section 241.3 is enacted | New hybrid offence for failing to comply with safeguards in providing medical assistance in dying |
| New section 241.4 is enacted | New hybrid offences for forging medical assistance in dying documents or destroying such documents with criminal intent<br><br>Definition of "document" |
| **Clause 4 of the Bill** | |
| New section 241.31 is enacted<br><br>*Will be brought into force at a later date when regulations are ready* | Creates an obligation on the Minister of Health to make regulations that she considers necessary to create a monitoring regime, and to create guidelines, in cooperation with PTs, regarding information to be included on death certificates<br><br>Creates legal obligations on medical practitioners, nurse practitioners and pharmacists to provide information on medical assistance in dying requests, in accordance with the regulations<br><br>Creates offences for failing to provide reports or for knowingly breaching regulations |
| **Clause 5 of the Bill** | |
| New offence (241.4(2)) of destroying documents is amended<br><br>*Will be brought into force at a later date when regulations are ready* | Adds an additional criminal intent ("to interfere with the provision of information" under the monitoring regime) to the offence of destroying documents, to address conduct that could arise after the regulatory requirement to provide information (monitoring) is in place |
| **Clause 6 of the Bill** | |
| Section 245 of the *Criminal Code* is amended | Exemptions are added to the current offence of administering a noxious substance for lawful medical assistance in dying |
| **Clause 7 of the Bill** | |
| Section 3 of the *Pension Act* is amended | Provides that where a person dies by medical assistance in dying, this is not considered improper conduct that would disqualify family members of Canadian Forces members and veterans from receiving pension benefits |
| **Clause 8 of the Bill** | |
| Section 19 of the *Corrections and Conditional Release Act* is amended | Provides that where an inmate dies by medical assistance in dying, this does not trigger an investigation into their death |
| **Clause 9 of the Bill** | |
| Section 2 of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* is amended | Provides that where a person dies by medical assistance in dying, this is not considered improper conduct that would disqualify family members of Canadian Forces members and veterans from receiving pension benefits |
| **Clause 9.1 of the Bill** | |
| Statutory duty to undertake 3 studies | Creates a statutory obligation on the Ministers of Justice and Health to undertake 3 studies on mature minors, advance requests and requests where mental illness is the sole underlying medical condition:<br>• no later than 6 months after the *Act* receives royal assent |

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| | • must report back to Parliament no later than 2 years after the reviews are initiated |
| **Clause 10 of the Bill** | |
| Parliamentary review | A Parliamentary review of the provisions of the *Act* and the state of palliative care in Canada will be launched 5 years after its coming into force |
| **Clause 11 of the Bill** | |
| Coming into force of Clauses 4 and 5 by Order in Council | The monitoring regime and related provisions will come into force no later than 12 months after royal assent (other clauses come into force on royal assent) |

# Annex B: Relevant Excerpts from *Carter v Canada (Attorney General)*, [2015] 1 SCR 331

In *Carter*, the Supreme Court held that the absolute prohibition on assisted dying unjustifiably infringes section 7 of the *Charter*, issuing the following declaration of invalidity:

> The appropriate remedy is therefore a declaration that section 241(b) and section 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. (para. 127)

***A Contextual Interpretation of Carter***

Read in isolation, the declaration appears to describe a right that is broad. The Court does not expressly limit the right to dying individuals; the term "grievous and irremediable medical condition" is not defined, and if given a dictionary definition, it could include conditions that are not life-threatening or terminal; and the declaration is framed largely in terms of subjective criteria (i.e., suffering that is intolerable to that person).

Read in its entirety, however, the judgment points to a more limited right and more limited understanding of the meaning of "grievous and irremediable medical condition". Aspects of the ruling that support a narrower interpretation include the following:

- The factual circumstances that that formed the basis of the case were those of Ms. Taylor, who suffered from the fatal disease of ALS and who was nearing a natural death. The Court made this clear throughout the judgment and in its declaration of invalidity
    - "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought" (para 127);
    - In at least 4 passages, the Court limits its holding to *Ms. Taylor and people like her* ("the prohibition on physician-assisted dying infringes the right to life, liberty and security of Ms. Taylor and of persons in her position" (para 56, see also paras 65, 66, 70 and 126));
    - Other witnesses referred to by the Court suggest what "people like Ms. Taylor" could mean:
        - "Other witnesses also described the […] suffering from a grievous and irremediable illness [...] some witnesses described the progression of degenerative illnesses like motor neuron diseases or Huntington's disease, while others described the agony of treatment and the fear of a gruesome death from advanced-stage cancer" (para 14).

- Medical assistance in dying is compared to forms of "end-of-life" care that are only available to dying individuals:
    - "Based on the evidence regarding assessment processes in *comparable end-of-life medical decision-making* in Canada, the trial judge concluded that vulnerability can be assessed on an individual basis… *Concerns about decisional capacity and vulnerability arise in all end-of-life medical decision-making*. Logically speaking, there is no reason

to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying" (para 115);
    - "An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows *people in this situation* to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying" (para 66);
    - Describing the findings of fact of the trial judge, which the Supreme Court did not disturb: "After considering the evidence of physicians and ethicists, she found that the 'preponderance of the evidence from ethicists is that there is *no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death'*" (para 335 from trial judgment; para 23 from the SCC ruling).

- The Court suggested that certain categories of people who might seek assistance in dying were excluded from the scope of its ruling:
    - "Professor Montero's affidavit reviews a number of recent, controversial and high-profile cases of assistance in dying in Belgium which *would not fall within the parameters suggested in these reasons*, such as euthanasia *for minors* or *persons with psychiatric disorders* or minor medical conditions.…". (para 111).

***SCC recognized Parliament's Policy Role including Need to Balance Diverse Interests***

Jurisprudence before *Carter* has recognized that in complex matters of social policy, involving competing interests and conflicting social science evidence, Parliament is better placed than courts to determine how the various interests should be balanced and how the evidence should be weighed. Provided that Parliament's response falls within a range of reasonable alternatives, deference will be given. In *Carter* the Court recognized that assisted dying is such an issue and suggested that a high degree of deference would be given to the solution developed by Parliament:

- "This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable" (para. 2);

- "The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But section 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life 'is no longer seen to require that all human life be preserved at all costs'" (para 63);

- "…in some situations the state may be able to show that the public good — a matter not considered under section 7, which looks only at the impact on the rights claimants — justifies depriving an individual of life, liberty or security of the person under section 1 of the *Charter*. More particularly, in cases such as this where the competing societal interests are themselves protected under the *Charter*, a restriction on section 7 rights may in the end be

found to be proportionate to its objective" (para 95);

- There may be "a number of possible solutions to a particular social problem" (para 97);
- That "physician-assisted death involves complex issues of social policy and a number of competing societal values. Parliament faces a difficult task in addressing this issue; it must weigh and balance the perspective of those who might be at risk in a permissive regime against that of those who seek assistance in dying" (para 98);

- "Complex regulatory regimes are better created by Parliament than by the Courts" (para 125);

- The choices made by Parliament in a complex regulatory regime would garner a higher degree deference than did the prohibitions (para 98).

The Court has also acknowledged in a number of cases that a law passed by Parliament may differ from a regime envisaged by the Court without necessarily being unconstitutional:

- "Just as Parliament must respect the Court's rulings, so the Court must respect Parliament's determination that the judicial scheme can be improved. To insist on slavish conformity would belie the mutual respect that underpins the relationship between the courts and legislature that is so essential to our constitutional democracy" (*R. v. Mills*, [1999] 3 S.C.R. 668 at para. 55).

# Annex C: Overview of Existing Medical Assistance in Dying Regimes

| State or Country | Type of Medical Assistance in Dying | Eligibility Criteria | Safeguards |
|---|---|---|---|
| **Oregon (1997), Vermont (2013), Washington (2008), California (2015)** | Physician-assisted suicide only | Patient must be terminally ill with less than 6 months to live<br>Terminal disease: incurable / irreversible disease that will, within reasonable medical judgment, produce death within six months<br>(Mental disorders alone: not eligible)<br>Adults only<br>No advance directives | Approval of request: Attending physician + 1 consulting physician + mental health specialist if needed<br>Oral + written requests<br>Written request in prescribed form signed before 2 independent witnesses<br>Time delays between oral requests, between written request and prescription<br>Patient may rescind request at any time |
| **The Netherlands (2002)** | Physician-assisted suicide and voluntary euthanasia | Patient must be suffering intolerably, either physically or mentally, with no prospect of improvement<br>Minors 12 years and older<br>Advance directives | Attending physician + 1 consulting independent physician<br>Patient may revoke request at any time |
| **Belgium (2002)** | Voluntary euthanasia | Patient has a medically futile condition and is experiencing constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident<br>Adults and emancipated minors<br>Minors younger than emancipated minors (of any age) but only where dying in the short term and experiencing unbearable physical (not mental) suffering<br>Advance directives only where patient irreversibly unconscious | Attending physician + 1 consulting independent physician<br>Physician talks to patient at reasonable intervals to verify persistence of request; written request signed<br>Consult with nursing team or relatives if patient desires; if not terminal, must consult with psychiatrist or expert and 1 month delay after request; if child must consult with child psychiatrist or psychologist<br>Patient may revoke request at any time |

| State or Country | Type of Medical Assistance in Dying | Eligibility Criteria | Safeguards |
|---|---|---|---|
| **Luxembourg (2009)** | Physician-assisted suicide and voluntary euthanasia | Patient has a medically futile condition, caused by illness or accident, and is experiencing constant and unbearable physical or mental suffering that cannot be alleviated<br>Adults only<br>Advance directives only where patient irreversibly unconscious | Attending physician + 1 consulting independent physician<br>Physician talks to patient at reasonable intervals to verify persistence of request; written request signed<br>Consult with medical team, other physicians treating patient or designated substitute decision-maker unless patient objects<br>Patient may revoke request at any time |
| **Québec (2014)** | Voluntary euthanasia | Patient must be at the "end-of-life" + suffering from an incurable serious illness + in an advanced state of irreversible decline in capability + experiencing constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable<br>(Mental disorders alone: not eligible)<br>Adults only<br>No advance directives | Physician + 1 consulting physician<br>Consult with members of care team and/or family (if patient wishes)<br>Written request in prescribed form; signed before 1 witness<br>Physician talks to patient at reasonable intervals to verify persistence of request<br>Patient may revoke request at any time |
| **Colombia (2015)** | Voluntary euthanasia | Terminal patient: serious condition or pathology that is progressive and irreversible with a prognosis of approaching death or death within a relatively short timeframe, and that is not susceptible to a proven effective healing treatment that would change the prognosis<br>(Mental disorders alone: not eligible)<br>Adults only<br>Advance directives if patients become no longer capable of expressing their wishes in the future | Attending physician + medical expert(s) if uncertain diagnosis<br>Interdisciplinary committee composed of medical specialist, lawyer and mental health expert must review request and confirm wish to die within 10 days of receiving request; must ensure request is carried out within 15 days of patient re-iteration of request; can suspend request if irregularities<br>Patient may revoke request at any time |

# Annex D: Overview of Recent Foreign Medical Assistance in Dying Bills

| State or Country | Type of Medical Assistance in Dying | Eligibility Criteria | Safeguards |
|---|---|---|---|
| **US States (Alaska, Arizona, Colorado, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire (study), New Jersey, New York, North Carolina, Rhode Island, Tennessee (study), Utah, Wisconsin)**<br><br>**(considered by or currently before State legislatures)** | Physician-assisted suicide only | Patient must be terminally ill with less than 6 months to live<br><br>Terminal disease: incurable / irreversible disease that will, within reasonable medical judgment, produce death within six months; Tennessee: at least 2 physicians must diagnose terminal condition<br><br>(Mental disorders alone: not eligible)<br><br>Adults only (except Hawaii: at least fifty years of age)<br><br>No advance directives | Approval of request: Attending physician + 1 consulting physician + mental health specialist if needed<br><br>Oral + written requests; Iowa: for patients incapable of making oral request, a written submission to the attending physician will be required; Alaska: patients incapable of signing request may direct a proxy to sign on behalf; and oral requests may be made using various means (e.g. electronic devices); Tennessee: written request must be notarized<br><br>Written request in prescribed form signed before 2 independent witnesses; Hawaii: if patient is in health care facility, 3rd witness designated by facility<br><br>Time delays between oral requests, between written request and prescription<br><br>Patient may rescind request at any time |

| State or Country | Type of Medical Assistance in Dying | Eligibility Criteria | Safeguards |
|---|---|---|---|
| **South Australia (Adjourned at Second Reading in June 2016)** | Voluntary euthanasia | Patients must be suffering from medical condition (whether terminal or not) that is unbearable to the person (determined subjectively) and hopeless (determined by reasonable availability of medical treatment to reduce/relieve suffering)<br>Adult only<br>No advance requests | Approval of request: Attending physician + 1 consulting physician + psychiatrist if deemed necessary by attending physician<br>Written request in prescribed form; signed in presence of independent witness and attending physician<br>Time delay between request and administration of medication<br>Patient may revoke request at any time |
| **New Zealand (Private Member's Bill in Parliament)** | Physician-assisted suicide and euthanasia | Competent adults who suffer from a terminal illness likely to die within 6 months or have a grievous and irremediable medical condition; advanced state of irreversible decline in capability; and unbearable suffering that cannot be relieved in a manner they consider tolerable<br>No advance requests | Approval of request: attending physician + 1 consulting physician + 1 mental health specialist if necessary<br>Oral and written requests; written request in prescribed form signed before 1 independent witness and in the presence of the attending physician |
| **France**<br>**(adopted January 27, 2016)** | Does not permit medical assistance in dying<br>Permits terminal palliative sedation | Conscious patients with serious and incurable disease, and who decide to stop taking medication or whose treatment no longer successful<br>Patients have the right to refuse artificial life-support treatments<br>Advance directives: adults can express their preference not to be kept alive by medical interventions, should they become too ill to make that decision | Patients can designate a person (e.g. relative or attending physician) who could be consulted in cases where patients are not able to express their wishes with regards to their advance directives<br>Advance directives can be modified or cancelled at any moment<br>Creation of a national registry of advance directives |
| **Germany**<br>**(November 6, 2015)** | Prohibits the commercialization of assisted suicide | This legislation criminalizes organizations that assist patients in terminating their own lives for profit, and includes penalties of up to three years of imprisonment; prevents the commercialization of the procedure as a "suicide business" | |

| State or Country | Type of Medical Assistance in Dying | Eligibility Criteria | Safeguards |
|---|---|---|---|
| **United Kingdom**<br>**(defeated September 2015)** | Physician-assisted suicide only | Patients must be competent adults diagnosed by a registered medical practitioner as having a terminal illness and reasonably expected to die within six months<br>Terminal illness is defined as "an inevitably progressive condition which cannot be reversed by treatment"<br>No advance directive | Approval of request: Attending physician + 1 consulting physician; approval by Family Court<br>Written request in prescribed form; signed in presence of one independent witness and countersigned by attending physician<br>Time delays between written request and delivery of medication |
| **Scotland**<br>**(defeated on May 27, 2015)** | Physician-assisted suicide only | Competent individual (at least 16 years old) suffering from an illness that is terminal or life-shortening or a condition that is, for them, progressive and either terminal or life-shortening<br>No advance directive | Approval of request: 2 registered medical practitioners<br>Three written requests in prescribed forms; signed in presence of qualified witness and confirmed by medical practitioner<br>Time delay between requests |
| **New South Wales (defeated on May 23, 2013)** | Physician-assisted suicide and voluntary euthanasia | Patients must be suffering from an illness that will, in the normal course, result in death; illness is causing severe pain, suffering or distress to an extent unacceptable to the patient; there is no medical measure acceptable to the patient that can reasonably be undertaken in the hope of effecting a cure<br>No advance request | Approval of request: 2 medical pracititioners + independent qualified psychiatrist + independent qualified social worker, if necessary<br>Oral and written requests; signed by patient and both medical pracititioner; interpreters, if required by the patient, may be required to sign the request form to confirm patient's understanding of the request; proxy may be used to sign certificate on patient's behalf<br>Time delay between requests<br>Patient may rescind request at any time and in any manner |

| | | | |
|---|---|---|---|
| **Tasmania (defeated on October 17, 2013)** | Physician-assisted suicide and voluntary euthanasia | Patients must have incurable and irreversible medical condition caused by an illness, disease or injury, causing persistent and intolerable suffering, and that is in advanced stages with no reasonable prospect of improvement<br>No advance requests | Approval of request: Attending physician + 1 consulting physician<br>Two oral and one written requests; written request signed before 2 independent witnesses<br>Time delays between requests<br>Patient may rescind request at any time |
| **Parliament of Victoria (study, June 2016)** | Physician-asssisted dying and voluntary euthanasia (where patients are physically unable to take lethal drug) | Capable adult (18+) at end of life (final weeks or months of life) suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable<br>Mental illness only: not eligible<br>No advance directives | Approval of request: 2 properly qualified and independent doctors + 1 psychiatrist if required<br>Two oral and one written request signed by 2 independent witnesses<br>Patient may withdraw request at any time |

# Annex E: Bibliography on Medical Assistance in Dying

## LEGAL/MEDICAL RESEARCH AND COMMENTARY

### *Canada*


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***Luxembourg***

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