

Canada on course to introduce permissive assisted dying regime

Udo Schuklenk

Correspondence to

Dr Udo Schuklenk, Department of Philosophy, Queen's University, Watson Hall, Kingston, Ontario, Canada, ON K7L 3N6; udo.schuklenk@gmail.com

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ABSTRACT

Canada's Supreme Court decided in February 2015 that the criminalisation of assisted dying in the country violates the country's citizens and residents constitutional rights. This paper reviews policy recommendations produced by a special expert advisory panel appointed by Canada's provinces and territories, where the responsibility for the provision of health care lies. It also reviews a similar document produced by a special federal parliamentary committee. Based on the review of these two milestone documents it is argued that a Canadian consensus seems to emerge that foreshadows a permissive regulatory regime in that country.

Canada's legislators are moving quickly to introduce what will likely be assisted dying legislation not dissimilar in scope to those in existence in a number of European jurisdictions like the Netherlands and Belgium. The Supreme Court of Canada gave the government time until June 6, 2016 to change the country's Criminal Code in order to ensure that 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' will be able to receive assistance in dying, both by means of voluntary euthanasia as well as by means of physician-assisted suicide (*Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331).

The Supreme Court's decision was preceded by a high-profile report of an international expert panel appointed by the country's Royal Society, recommending that assisted dying be decriminalised for people meeting exactly the criteria settled on by the court.¹ Since then the predominantly French-speaking province of Quebec introduced, as the first province in the country, assisted dying legislation.² The availability of legal assisted dying enjoys overwhelming public support in that province, as well as cross-party support in its legislature. At the last minute opponents of assisted dying succeeded in raising the access threshold from being a competent adult suffering an irreversibly low quality of life which that adult does not consider worth living by adding a further access criterion: the person must also be towards the end of their lives. The Supreme Court, quite deliberately, did not limit access to patients suffering a terminal illness (terminal illness defined as within 6 months of death). The legislation in Quebec is bound to be contested in the courts by patients seeking an assisted death who are suffering, for instance from

treatment-resistant depression but who are not terminally ill. It also limits access to persons of full age and Quebec denies its citizens the right to issue legally binding advance directives. I will contrast this further below with what emerges as the Canadian consensus on these issues.

It has been uncontroversial in Canada, since the Supreme Court decision in February 2015 that assisted dying would come to the country, what was less clear was whether forces opposed to its introduction would be able to delay its introduction, and to what extent they would be able to limit the number of people eligible for access to it. Assisted dying policies in the country require federal and provincial legislators to work together to some extent, because the offending lines in the Criminal Code that the Supreme Court set aside are only one side of the coin, and they require the federal parliament to act. The other side of the coin is that health-care is a provincial matter, and provincial legislators are therefore required to introduce the nut-and-bolt-type legislation that would regulate assisted dying within their provincial healthcare systems.

On a federal level nothing happened on the legislative frontiers since the February 2015 court judgement, because during that time the conservative Prime Minister and his parliamentary caucus were implacably opposed to assisted dying. Its case in front of the Supreme Court of the country sank essentially without a trace in the court's unanimous decision declaring the criminalisation of assisted dying unconstitutional. This was all the more remarkable as the majority of judges on the court were appointed by the same conservative Prime Minister. A change of government in the end of 2015 brought about a new, liberal Prime Minister and a change of attitude towards assisted dying on the federal level. The provinces and territories appointed a joint expert panel and tasked it with advising the provincial and territorial governments on how to draft legislation in line with the Supreme Court's ruling. The same happened under the new federal government. It appointed a special joint parliamentary committee consisting of members of the House of Commons and members of the Senate, to draft recommendations for the government to consider when it produces its legislation. Both the provincial panel³ as well as the federal parliamentary committee⁴ have issued their respective reports.

Leaving aside a host of operational issues, both the parliamentary special joint committee as well as the provincial-territorial panel had to address two controversial questions: (1) scope (ie, who should be eligible to receive assistance in dying on their



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request) and (2) conscientiously objecting healthcare professionals (as well as a corollary of this, namely the availability of assisted dying in religious healthcare institution opposed to assisted dying).

SCOPE

Remarkably, a significant overlap in the recommendations of both groups can be found in their respective reports on these matters. These two documents combined arguably constitute the Canadian consensus on this subject matter. Both conclude—in line with the Supreme Court decision—that terminal illness should not be an access threshold criterion. Both also agree that age should not be an access threshold, rather competence of the person requesting assistance in dying is the crucial threshold criterion. This would give competent treatment-resistant depressed people (or other people suffering mental illnesses that do not render them incompetent and that render their lives irreversibly not worth living to them) the right to ask for an assisted death. The parliamentary group heard an expert's warnings⁵ that this had led Belgium down a slippery slope resulting in the termination of the lives of mentally ill patients who—in his judgement—should not have been assisted. The parliamentarians were not persuaded by the evidence presented and noted in their recommendations that 'cases involving mental illness may prove challenging to address for health care practitioners, but the Committee has faith in the expertise of Canadian health care professionals to develop and apply appropriate guidelines for such cases. The difficulty surrounding these situations is not a justification to discriminate against affected individuals by denying them access to medical aid in dying (MAID).' The Committee expects that cases where the underlying condition is a mental health condition will be rare, as is the case in other jurisdictions that have legalised MAID.⁶ The provincial-territorial expert panel came to the same conclusion.⁷ This strongly suggests that a consensus has been reached by the relevant players on this controversial subject matter. The parliamentary special joint committee recommended, on the equally controversial subject of children's eligibility for an assisted death, that the government immediately implement its recommendations for competent adults, and that this be extended to mature minors within 3 years. It also recommends that the government study as a matter of urgency the moral, medical and legal implications of the 'mature minor' concept.⁸ This goes beyond the minimum required by the Supreme Court of Canada's decision, but it is consistent with the view that what matters is a person's competence. It also mirrors the recommendations of the provincial-territorial expert panel.⁹

CONSCIENCE

Protections of conscientiously objecting doctors have been high on the agenda of religious opponents of assisted dying as well as of the Canadian Medical Association.¹⁰ Groups of religious objectors¹¹ are currently taking statutory bodies such as the Ontario College of Physicians and Surgeons to court, because of the newly introduced requirement¹² that conscientious objectors must transfer assistance-seeking eligible patients to healthcare professionals who will provide that assistance. Both the Canadian Medical Association as well as the Christian Medical and Dental Society of Canada insist that doctors should neither be compelled to provide assistance in dying, nor be required to transfer patients on to someone they know will provide that assistance. The consensus view expressed both by the provincial-territorial expert panel as well as the parliamentary special joint committee in its recommendations is that while doctors should

not be compelled to provide assistance in dying, they should be obliged to refer patients to a provider who will. There are sound ethical reasons for such a policy.¹³

A related issue affects the fairly large number of hospitals operated by religious (typically Christian) organisations. In many parts of the country such hospitals would be the only healthcare facility able to provide assistance in dying to eligible people. Unsurprisingly, these operators are opposed to providing such medical services, citing conscience and freedom of religion-related issues. The parliamentary special joint committee holds the view that such healthcare facilities must provide assistance in dying if they are publicly funded.¹⁴ This, of course, is true for virtually all of these healthcare facilities. There is no sound ethical reason for permitting a hospital managed by a sectarian group to limit the kinds of professional medical services patients can receive in said hospital, if the hospital happens to be publicly funded.

COMMENT

Canada is well on its way to creating an assisted dying regime that is as permissive as that in countries like the Netherlands and Belgium. The national media, courts on various levels, expert panels as well as parliamentarians, surveyed the available evidence from these and other jurisdictions and concluded that such a permissive regime can be safely administered. Those campaigning against assisted dying did themselves no favour when they fairly consistently exaggerated the threats of assisted dying regimes to the so-called 'vulnerable'. They barely managed to hide that what was driving their opposition were religious convictions that were not shared by the overwhelming number of their fellow citizens. Their campaign failed spectacularly because in this day and age their claims of fact could easily and quickly be investigated and debunked.

The other lesson, from Canada at least, is that what was required to drive the change that is now coming was court action. The same parliament that is now proposing what is a highly desirable assisted dying regime did not respond in the past to the pressure of public opinion, persuasive arguments provided by Canadian researchers such as Jocelyn Downie¹⁵ and groups such as Dying with Dignity. What drove the change were desperately suffering Canadians who took their government to court because its laws were violating their constitutional rights. The Supreme Court listened to their arguments, evaluated the available evidence from permissive jurisdictions and took undoubtedly into account the overwhelming public support for the changes that are now coming. It forced the parliamentarians' hand with its February 2015 decision.

Doctors' lobby groups, such as the Canadian Medical Association, and religious doctors' groups clearly overplayed their hand when they decided to take a hardline stance on the question of conscientious objection. They lobbied governments to be given the right to refuse to provide either assistance or transfer patients on to a professional who would provide the service. It became clear that, despite protestations to the contrary, patient interests and medical professionalism were the least of these groups' concerns. The Canadian Medical Association turned out to be no different to a trade union lobbying for their members' parochial self-interest.¹⁶ Its representatives argued that patients would be able to find doctors willing to oblige them, given that surveys indicated that about 30% of Canadian doctors—in an unscientific online survey conducted by the association—were willing to provide such a service. This argument is oblivious to Canada's geographical spread, and on that ground alone it is impossible to guarantee access based on that survey's result. It is a well-known fact that women wanting

to access abortion in Prince Edward Island are unable to access this service in the province due to conscientious objectors there. Travel requirements are a well-established, efficient barrier to access.¹⁷ If the Canadian Medical Association had its way, doctors could erect the same barriers in front of desperately suffering vulnerable patients seeking assistance in dying. The parliamentary special joint committee as well as the provincial-territorial expert panel recommended that in addition to doctors, nurse practitioners and nurses working under the supervision of a doctor may also render assistance in dying.¹⁸ The federal committee, also in response to this concern, recommended that medical aid in dying should be provided in all publicly funded hospitals.¹⁹

The federal government must now produce legislation and introduce it for debate in the country's parliament. The same holds true for the country's provinces and territories. It will be interesting to see how these respective governments deal with the advice they received from the people they appointed to advise them.

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