Canada on course to introduce permissive assisted dying regime

Udo Schuklenk

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. Since then the predominantly French-speaking province of Quebec introduced, as the first province in the country, assisted dying legislation. 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 healthcare 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 front 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 panel as well as the federal parliamentary committee 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
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 warnings 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. The provincial-territorial expert panel came to the same conclusion. 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 the question of conscientious objection. They lobbied governments to take a hardline stance on the question of conscientious objection. They lobbied for their members 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 pro-life arguments provided by religious doctors such as Jocelyn Downie 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 the decision to allow Canadians to die with dignity. The parliamentary group heard an expert’s warnings 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. The provincial-territorial expert panel came to the same conclusion. 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 the question of conscientious objection. They lobbied governments to take a hardline stance on the question of conscientious objection. They lobbied for their members 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 pro-life arguments provided by religious doctors such as Jocelyn Downie 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 the decision to allow Canadians to die with dignity.
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.

Competing interests  None declared.

Provenance and peer review  Commissioned; internally peer reviewed.

REFERENCES


7 Provincial-Territorial, 2015, p. 36.


9 Provincial-Territorial, 2015, p. 37.


19 Parliament of Canada, 2016, p. 27.
Canada on course to introduce permissive assisted dying regime

Udo Schuklenk

doi: 10.1136/medethics-2016-103506

Updated information and services can be found at: [http://jme.bmj.com/content/42/8/490](http://jme.bmj.com/content/42/8/490)

**References**

This article cites 1 articles, 0 of which you can access for free at: [http://jme.bmj.com/content/42/8/490#BIBL](http://jme.bmj.com/content/42/8/490#BIBL)

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Topic Collections**

Articles on similar topics can be found in the following collections

- **Editor's choice** (121)

**Notes**

To request permissions go to: [http://group.bmj.com/group/rights-licensing/permissions](http://group.bmj.com/group/rights-licensing/permissions)

To order reprints go to: [http://journals.bmj.com/cgi/reprintform](http://journals.bmj.com/cgi/reprintform)

To subscribe to BMJ go to: [http://group.bmj.com/subscribe/](http://group.bmj.com/subscribe/)