

**Honours Thesis**

**Law, Vulnerability and Medical Assistance in Dying in Canada:  
A Post-*Carter* Policy Review**

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**Spring 2017**

**Author Note**

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### ***Abstract***

This project focuses on assisted-dying policy in Canada; assisted-dying was legalized in February 2015 as per the *Carter v. Canada (Attorney General)* (2015) ruling, because the longstanding blanket prohibition of assisted-dying was found to be unconstitutional as it violated the plaintiff's s. 7 right to life, liberty and security of the person. In June 2016, Bill C-14: *An Act to Amend the Criminal Code and to make related amendments to other Acts* (2016) was enacted federally. One of the main concerns from various sources regarding this legislation is that an individual's natural death must be reasonably foreseeable to access MAID. Bill C-14 (2016) excludes individuals who do not have a 'foreseeable natural death' from accessing medical assistance in dying. The current policy has not found a balance between the need to protect vulnerable populations from becoming victims to assisted-dying and is not accessible to those who are suffering from non-terminal illnesses or are deemed vulnerable.

The methodology used in this research was a policy analysis, using court cases/rulings, federal legislation, provincial policies, transcripts, and legislative backgrounds/summaries. In addition, the co-investigator conducted two one-on-one semi-structured interviews to supplement the main data.

*Keywords: assisted-dying, physician assisted-dying, medical assistance in dying (MAID), euthanasia, Charter of Rights and Freedoms, Bill C-14 (2016), life, liberty, security of the person, Charter rights, suspended declaration of invalidity, principles of fundamental justice, Carter v. Canada, Julia Lamb, Rodriguez v. British Columbia, Canada v. Bedford, advanced consent, mature minors, mentally ill, vulnerability, disability, terminally ill, reasonably foreseeable, Charter dialogue, policy, law, unconstitutional, violation of rights, s. 7*

### *Acknowledgements*

First and foremost, I would like to thank my supervisor throughout this process, Prof. Irina Ceric. This journey throughout honours was met with many bumps along the way and I want to thank you for your compassion and help in motivating me to complete this project. You have been a wealth of knowledge and I have learned so much more from working with you. Thank you for being my supervisor and thank you for helping me stay on the right track.

Mike Larsen, I want to thank you for your encouragement throughout this entire project and for the support that I have received from you throughout my academic career; I would not have applied for Honours without your recommendation and so thank you for reading and providing feedback on so many of my assisted-dying papers.

Dr. Tara Lyons thank you for being my internal reader, I really appreciate it.

Dr. Charmaine Perkins thank you for being my external reader, I am very grateful.

To my colleagues and friends in Honours—thanks for commiserating with me and encouraging me to finish this project!

To my close friends, family and Scott—thank you for supporting me and encouraging me to follow my dreams. By now you'll all be fed up of discussing every single news article, piece of data or policy that I wanted to stay up all night talking about. Thank you for having open ears, and telling me to get my work done.

To Bucky (my grandmother). Thanks for educating me and sharing your thoughts on right-to-die laws. Hopefully this finished project will brighten your 'golden years.' Thanks for encouraging me to pursue this and thanks for listening to me read all my drafts!

Thank you to the Librarians at both the Surrey and Langley KPU campuses, specifically Chris Burns; the documentaries and books I've requested were very useful in this project.

Thank you to those individuals that participated in my research, the interviews were one of my favourite parts of this project and I finally got to ask questions I was dying to have answers to.

Thank you to all the others whom I haven't named above for helping me along the way throughout this project.

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## *Chapter 1*

### *Introduction: Current Context of Assisted-Dying Law in Canada*

Before 2015, Canadians were unable to receive medical-assistance in dying. This was because of the prohibitive ban that prevented physicians from aiding or counseling an individual in their suicide. These acts were prohibited under section 241 of the *Criminal Code* R.S.C., 1985, c. C-46 [hereinafter *Criminal Code*] until the Supreme Court of Canada ruled in *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331 [hereinafter *Carter*, 2015] that this legislation infringed upon section 7 of the *Charter*. Bill C-14 (2016) excludes individuals who do not have a ‘foreseeable natural death’ from accessing medical assistance in dying. The current policy has not found a balance between the need to protect vulnerable populations from becoming victims to assisted-dying and is not accessible to those who are suffering from non-terminal illnesses or are deemed vulnerable. Vulnerability is a difficult concept for legislation to define and this is representative of the misguided blanket protection that has occurred in the past. The consequences of not acting on the recommendations provided by those who have completed thorough research, as well as ignoring the voices in the discussion will ultimately lead to Canadian citizens to lack access to a now legal right, and thus, infringe on the *Canadian Charter of Rights and Freedoms*.

This topic was chosen for the requirements of an Honours Thesis in Criminology at Kwantlen Polytechnic University. This topic has been an interest of mine for about seven years. I was first introduced to the medico-legal aspect of assisted-dying whilst being admitted early into a Law 12 course in the beginning of high-school. I first learned of Sue Rodriguez (who is discussed within this thesis) with complete shock that it was possible to be denied the right to die with dignity. This was nearing the time that I began caregiving for my elderly grandmother who

has been living in a state of suffering for the past 7 years. Quality of life can begin to diminish with age very quickly and take away a person's independence and dignity. The ultimate incurable 'disease' is age itself and it has vastly opened my eyes to the importance of dignity, quality of life, and autonomy. It has been my passion throughout my time at Kwantlen Polytechnic University to navigate and research different aspects of assisted-dying and to follow this timely and very significant aspect of Canadian law and policy.

As an introduction to this thesis, there are three definitions to consider:

***Assisted dying*** is a generic term referring to a form of euthanasia; it is defined by the *Report of the Special Joint Committee on Physician-Assisted Dying* as "the act of intentionally ending one's life with the assistance of another person who provides the knowledge, means, or both, of doing so" (Ogilvie & Oliphant, 2016, p. 9).

***Physician-assisted dying*** (PAD), is another term for assisted dying, referring to the fact that the doctor is assisting in the suicide (Ogilvie & Oliphant, 2016).

***Medical assistance in dying*** (MAID) is the terminology used in Quebec. MAID is also the term used in the federal Bill C-14: *An Act to amend the Criminal Code and to make related amendments to other Acts* (medical assistance in dying) 2016.

Terminology regarding assisted-dying has been widely debated, so, as recommended by the Special Joint Committee, MAID or 'medical assistance in dying' was argued to be the best term used in Canadian legislation (Nicol & Tiedemann, 2016, p. 3). This term fits the need of the legislation because it "reflects the reality that health care teams, consisting of nurses, pharmacists, and other health care professionals are also involved in the process of assisted

dying” (Ogilvie & Oliphant, 2016, p. 10). Hereinafter, the terms that will be used interchangeably are assisted dying, PAD/physician-assisted dying and MAID/medical assistance in dying. These terms have been chosen to fit alongside the terminology used in Bill C-14 (2016) along with other publications.

Assisted dying has been a topic of discussion in Canada for many years, but up until very recently, it had not been legalized. Now that medical assistance in dying (MAID) has been implemented into Canadian law and policy, it has created a debate about the access and the process that is outlined in Canadian policy. Bill C-14 (2016) introduced legislation to regulate assisted dying for those who have a ‘reasonably foreseeable natural death’ (Bill C-14, 2016). This created changes to the *Criminal Code of Canada* that formerly prohibited the choice to help one to end their life as an assisted suicide (Browne & Russell, 2016). A key theme over the years has been that the prohibitive ban on PAD was strongly in favour of protecting the ‘sanctity of life’ (Chan & Somerville, 2016, p. 150) principle and protecting vulnerable populations from being subject to acts of euthanasia; this was one of the key principles that prevented the ban from being overturned in 1993 in *Rodriguez* (Downie & Bern, 2008). Section 241 of the *Criminal Code* was being considered from time to time to be a ‘blanket prohibition’ since it would ultimately protect Canadians, including those who are deemed vulnerable. The fight to legalize assisted-dying has made its presence known in the SCC through *Charter* challenges in some very renowned cases, specifically *Rodriguez v. British Columbia* (1993) and *Carter v. Canada* (2015).<sup>1</sup>

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<sup>1</sup> It is also important to note that Quebec produced their own province wide bill allowing assisted-dying in 2014 (Bill 52, 2014), but this policy was not a part of the data used in this research project.

In February 2015, the Supreme Court's ruling *Carter v. Canada* legalized PAD, forcing the federal government to reconsider the policy nationally. The ruling explained that the prohibitive bans on PAD infringed upon *Charter* rights, specifically of section 7 (Chochinov & Frazee, 2016). This is monumental for policy in Canada, but it is arguable that making these policies become practically implemented. Some individuals that are suffering considerably do not actually have an imminent death, so they ultimately do not meet the criteria that must be met within current Canadian policy (Chochinov & Frazee, 2016). Therefore, they cannot access this right—however, Julia Lamb and Robyn Moro (among other plaintiffs that have come forward) are arguing that they would like to be able to access this right, since, they do not want to lose their autonomy, dignity or sense of self (Chan & Somerville, 2016 & Globe & Mail, 2017). There is uncertainty whether Canadians will be able to make an autonomous decision to receive MAID with the new policy in Canada.

According to Dying with Dignity Canada (DWD) (2016), members of the Canadian population have changed their views drastically in the last few years, understanding that there are many factors that may invoke damage to an individual's quality of life, dignity, and autonomy (Dying with Dignity Canada, 2016). Thus, the call for these rights has now been answered. The importance of MAID research is now bigger than fighting for the decriminalization of PAD. Now, it is imperative to recognize that Canadian are living without the quality of life that they wish to live with, without access to treatment (palliative) (Chochinov & Frazee, 2016); or without the ability to end their life in a humane and dignified way. The federal legislation (Bill C-14, 2016) is representative of this, since those that do not suffer from an irremediable disease cannot access this right and the criteria for PAD should not be discriminatory.



Bill C-14 (2016) is a piece of legislation that is failing Canadians that wish to access MAID, and ultimately, it is unconstitutional legislation that replaces the previous legislation. However, with *Carter v. Canada* (2015) it became apparent that the SCC has recognized the acceptance of assisted-dying and placed a greater value of living a life of quality, with self-determination and liberty, rather than simply being alive or living. Moreover, the prohibitive ban impacted the entire population, not just providing those deemed vulnerable with protection (*Carter v. Canada*, 2015, para. 86), therefore, it was violating s. 7 rights to life, liberty and security of the person and deemed unconstitutional. Bill C-14 (2016) is just a revised way to prohibit individuals from making autonomous decisions regarding their life, and the policy quite clearly shows that the federal government does not wish to be held accountable for the possibility of vulnerable individuals being taken advantage of (aside from the statistics from around the world where MAID policies are working); Bill C-14 (2016) is new legislation, with the same purpose as the blanket prohibition of assisted-dying, and is therefore, a disgraceful representation of the necessary dialogue that should happen between a Supreme Court ruling and policy makers that are initiating a new policy or making amendments. Bill C-14 (2016) does not provide assurances for Canadians who wish to die with dignity, it only creates more uncertainty. I would argue further that the job of policy makers is not to determine who is vulnerable, but to create a policy that ensures that medical practitioners are providing assessments that do so; doing this would help MAID become accessible for those without a 'reasonably foreseeable' death. It is likely that Bill C-14 (2016) will eventually be found unconstitutional too, because of the 'reasonably foreseeable' criterion (*Dying with Dignity Canada*, 2016) It may take the federal government a long time to amend Bill C-14 (2016) so that it fits the needs of *all* members of society (with inclusivity of minorities such as those with disabilities and others that are classified

as vulnerable, such as those with psychological disorders). But in the meantime, it will be unfortunate if there are Canadians who will take their own lives prematurely or live in an intolerable state of suffering because of it.

In the following chapters, a thorough policy review will be undertaken, using court cases, parliamentary documents, reports, and legislation to help position and understand how policy has been implemented in Canada, and whether it provides safeguards for those who are vulnerable and if it is accessible to these populations. In addition, a literature review that examines the *Charter*, disability studies and vulnerability theory will also be conducted to position the methodology section of this thesis. There will be a short chapter of interview data to supplement the policy data, and to address the applicability of policy. In the analysis chapter, the literature and methodology section to the policy and data will be discussed. This thesis will close with a short discussion and conclusion of the thesis findings and provide some recommendations and explanations for future changes as well as major shortcomings.

### ***Methodology***

A qualitative mixed methods approach was used in this research project, using a policy analysis and two semi-structured interviews to supplement the main data source. This methodology is the most useful method to explore aspects of vulnerability and MAID policy in Canada because the policy has been enacted in the recent past and has been under much public scrutiny. The documents collected for this research were policy documents such as legislation, transcripts on legislative discussions, reports from special committees and provinces, summaries and backgrounds published by the government, as well as court cases, legal documents and other related materials.

A policy analysis was necessary for this kind of project because the legislation put into effect (Bill C-14, 2016, MAID) is not yet a year old, and so it was important to assess whether the legislation followed the SCC ruling (*Carter*). This policy analysis also required a thorough literature review to find theoretical perspectives to support, uncover and analyze the data collected. Using a policy analysis was useful to uncovering answers why and how the policies implemented for assisted-dying in Canada are applied to vulnerable populations, and whether or not they are successfully implemented. Gilson (2014) explains that policy analysis is derived from three main elements: understanding the dialogue between institutions, who's impacted by the policy, and the foundation of the policy (p. iii1). Combined with qualitative research, a policy analysis can be a useful tool for whether a policy is applicable to the audience which it is meant to reach (Gilson, 2014); in addition, there are steps that are used to conduct a policy analysis, and these methods were applicable to this research project. One of the first steps of this project was to identify important literature to be reviewed that was applicable to the assisted dying debate. This provided an abundance of research data—data which derived from numerous angles that were all relevant to assisted-dying but not all applicable to this research. So, a challenge that was faced was directing the research and simultaneously considering which articles, policies, guidelines and scholarly literature were useful to my project. This does not mean that this research is exhaustive, because it truly is not, but with the data used and chosen, the research speaks volumes to how the policy came to be, and how it can be improved. This task involved reviewing each document and determining whether it was applicable, but also which key themes were found and notes were taken. The final step taken in this project was to synthesize the main points of the findings and interpret it, with the hopes of creating further discussion on the topic.

### ***Semi-Structured Interviews***

The second method of research used in this project was one-on-one interviews following a semi-structured script. The interviews were with Dr. Ellen Wiebe, a physician at UBC and Cory Ruf of Dying with Dignity Canada. These interviews were meant to supplement the main data source and so they helped to fill in some of the missing gaps within the research. The goal for the interview portion of the research was to conduct between 4 and 10 interviews. The interview methods portion of this thesis and the interview findings are discussed in Chapter 3. An important point to note is that the interview participants had to already be involved in the MAID debate, either through work or through advocacy.

## ***Chapter 2***

### ***Research Data: Law, Policy, and Key Organizations***

This chapter will introduce the data used in the policy analysis method of this research. It will explain the major court rulings on assisted-dying in Canada, present the newly enacted legislation and some policies and federal organizations that have helped to transition the legalization of MAID into practice, and illuminate some of the main recommendations made by committees enacted federally prior to Bill C-14 (2016) becoming law.

#### ***Rodriguez v. British Columbia: A Landmark Decision***

In 1991, Sue Rodriguez was diagnosed with ALS, often known as Lou Gehrig's disease. This is a debilitating disease and would cause Rodriguez to suffer immensely and eventually become paralyzed (*Rodriguez v. British Columbia*, 1993). At this time, Switzerland was the only country that had legalized assisted-dying (Beaudoin, 2006). Rodriguez took her case to the B.C. Supreme Court seeking to invalidate section 241 of the *Criminal Code* which was prohibiting her from receiving assistance in ending her life; this request was made because of the harsh reality of her diagnosis—that eventually she would no longer be able to take her life, and she wished to do so in an autonomous and dignified way. Her request was dismissed, so she appealed to the B.C. Court of Appeal, and was met with the same response. In March 1993, Rodriguez appealed to the Supreme Court of Canada (SCC), arguing that s. 241 of the *Criminal Code* was violating her section 7, 12 and 15(1) *Charter* rights. Section 241 of the *Criminal Code* states that:

Everyone who ... (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years (*Criminal Code* R.S.C. 1985, c. C-46, as amended.)

Rodriguez argued that her s. 7 rights were being infringed upon because she was unable to take her own life without the assistance of another person and therefore her rights to ‘life, liberty and security of the person’ were violated. Rodriguez further argued that her s. 12 right to not be ‘subjected to any cruel and unusual punishment’ was being violated because without receiving assistance in her death, she would be experiencing intolerable suffering, for longer than necessary—this would be unnecessarily cruel. Finally, Rodriguez claimed that s. 15 of the *Charter* was violated because individuals have the “right to equal protection and equal benefit of the law without discrimination based on ...physical disability.” Sue Rodriguez was unable to take her own life and needed the assistance of another individual to do so, therefore, by depriving her of this right it is discriminatory, since she could not physically commit the action herself (*Rodriguez*, 1993, pp. 520-523).

The SCC issued a 5-4 decision on September 30, 1993, ruling that s. 241 of the *Criminal Code* was constitutional, and that the blanket prohibition of assisted-dying in Canada was meant to protect the vulnerable and the sanctity of life (*Rodriguez*, 1993, p. 521). In *Rodriguez*, the majority SCC found that her s. 7 rights were not infringed upon because the law was in accordance with the principles of fundamental justice (*Rodriguez*, 1993, p. 521). The SCC’s majority decision regarding the s. 12 challenge was that the government was not controlling Rodriguez by prohibiting her suicide—and so they were not prolonging her suffering. Rodriguez was not receiving ‘cruel or unusual punishment’ from the government itself, so this was not a violation of her rights (*Rodriguez*, 1993, p. 522). Regarding whether Rodriguez’s s. 15 rights were violated, the SCC stated:

It is preferable in this case not to decide the difficult and important issues raised by the application of s. 15 of the *Charter*, but rather to assume that the prohibition on assisted suicide in s. 241(b) of the *Code* infringes s. 15, since any infringement of s. 15 by s. 241

(b) is clearly justified under s. 1 of the Charter. (*Rodriguez v. British Columbia*, 1993, p. 522).

The majority of the SCC found that “the prohibition on assisted suicide in s. 241(b) of the *Code* infringes s. 15, since any infringement of s. 15 by 241(b) is clearly justified under s. 1 of the *Charter*” (*Rodriguez*, 1993, p. 6)). The importance to society to have a blanket prohibition on assisted-suicide was to provide safeguards for those who may become vulnerable, therefore, by withholding the right to assisted-suicide, it prevented a ‘slippery slope’ (*Rodriguez v. British Columbia*, 1993, p. 42) from occurring and protected those who are vulnerable, and fulfilled the intended purpose of the law.

The minority of the SCC felt that s. 7 rights were being infringed upon by upholding s. 241 of the *Criminal Code* and that the infringement was not in accordance with the principles of fundamental justice (*Rodriguez v. British Columbia*, 1993, p. 6). Justices L’Heureux-Dubé and McLachlin dissented that:

Parliament has put into force a legislative scheme which makes suicide lawful but assisted suicide unlawful. The effect of this distinction is to deny to some people the choice of ending their lives solely because they are physically unable to do so, preventing them from exercising the autonomy over their bodies available to other people. The denial of the ability to end their life is arbitrary and hence amounts to a limit on the right to security of the person which does not comport with the principles of fundamental justice. (*Rodriguez v. British Columbia*, 1993, p. 6.)

Chief Justice Lamer and Justice Cory were also among the dissenting Judges stating that the importance of autonomy was a right under s. 7’s guarantee of security of the person. Subjecting an individual to suffer intolerably and that “dying with dignity” should be a protected right as is the right to life (*Rodriguez v. British Columbia*, 1993, p. 6).

Arguments against Canada's new policy on assisted-dying are represented by the most recent *Charter* challenge, the ongoing *Lamb v. Canada* (2016) case since this Canadian woman could suffer for years on end before her disease ultimately takes her life naturally. Lamb is challenging the current legislation for PAD (Bill C-14) which is not addressing some individuals while still considering them to be vulnerable; these individuals unable to access MAID are: mature minors, mentally ill persons, non-terminally ill people, individuals with disabilities without a natural foreseeable death. MAID is inaccessible to these individuals because they do not meet the criteria, or, the legislation simply did not include them initially. Instead, an independent review was initiated 180 days after the enactment of Bill C-14 (2016) to assess mentally ill, mature minors, and advanced directives. This significantly undermines the *Carter v. Canada* (2015) ruling and arguably is infringing on the *Canadian Charter of Rights and Freedoms*—specifically the right to life, liberty, and security of the person (s. 7), as well as the right to not be subjected to cruel and unusual treatment (s. 12) and finally that the law would be applied without discrimination (s. 15 (1)). These sections of the *Charter* will be thoroughly discussed later in the analysis and literature review sections; however, bear in mind that these sections of the *Charter* are at the very heart of PAD policy and will likely be challenged again if they are not substantially addressed in the near future.

Several other countries have legalized assisted-dying, such as the Netherlands, Belgium, Switzerland and several states in the U.S.A. Some of these policies have been enacted for at least fifteen years (Collier, 2009). Since the enactment of PAD policy, the Netherlands (Vogel, 2012, p. E19) and Belgium have made amendments to policy, allowing individuals that are not terminally ill to make requests for PAD. Some notable changes to the policies in these countries



are the age restrictions being lifted (Chazan, 2016), and as recent as in September 2016, the first terminally ill minor received PAD in Belgium (Chazan, 2016).

Individuals opposing legislation provide the argument that policy makers are justifying their implementation of PAD policy because it is helping to resolve the issue that there are not enough palliative care facilities to help Canadians nearing the end of their lives. In fact, Vogel (2012) notes that “as many as 70% of Canadians lack access to hospice and palliative care and what programs exist are uncoordinated and unevenly distributed across the country” (p. E19). Although the access to proper palliative care and hospices may not prevent PAD from occurring (p. E19), the model of PAD in Oregon provides that these end-of-life managing options are necessary alongside PAD policy (E19). This ties in with the ‘slippery slope’ arguments of groups opposing PAD policy, because now that assisted suicide has been decriminalized, the fight for others to receive PAD, such as those who suffer from mental illnesses or other grievous pain (Vogel, 2012, E20).

The ‘slippery slope’ arguments are related to this; the ‘slippery slope’ argument related to PAD is that if assisted-dying becomes legal (which it has) “then there will be a slide towards the bottom of a slippery slope and many clearly unacceptable practices will become prevalent...we will soon find ourselves unable to prevent involuntary euthanasia of the elderly, the disabled, and other vulnerable individuals” (Downie, 2004, p. 117). Once the legalization has occurred, it is deemed that it will only be a matter of time before someone falls vulnerable to the policy (Vogel, p. E20). On one hand it has been true, more individuals are being able to access end of life decisions, to protect their dignity, autonomy and right to equal treatment without unnecessary suffering. On the other hand, to what extent are end of life decisions made by the patient and not

the physician assisting in it—or where will the line be drawn for whether it is a choice of pain management or euthanasia (Collier, 2009, p. 464).

Joint chairs on the Special Joint Committee on PAD, Ogilvie and Oliphant (2016), produced a parliamentary report with recommendations for PAD policy, directly addressing the fact that though *Carter v. Canada*'s ruling did not specifically pertain to cases where an individual was mentally ill or non-terminally ill patients, it is in the best interest of the legislation to address the importance of recognizing other grievous conditions such as severe mental illness, or non-terminal illnesses (p. 13). Ogilvie and Oliphant's (2016) report produced 21 detailed suggestions on how to frame PAD policy and implement it successfully (p. 35-36). The report noted that it is imperative that vulnerable populations are protected and that PAD implementation should be alongside furthering palliative care and other end of life means, so that PAD is not the only option available (p. 3). Ogilvie and Oliphant (2016) noted that an important part of policy to address is an option for advanced directives for those who are not yet in the final stages of their lives because the request for PAD is a lengthy process. Ultimately, one may wish to ensure that they have their right before it becomes inaccessible to them—such as in cases where an individual loses competency, or the ability to give consent (pp. 21-22). This is only the beginning of a very lengthy part of PAD discussion, and is arguably one of the most important aspects to consider when addressing the policy.

With the legalization of PAD, some physicians may still have their own moral beliefs regarding assisted-dying. Some physicians prefer not to participate or offer this form of medical care it has been discussed and regarded as an important aspect to the changes in legislation. Physicians will be able to refuse for legitimate reasons to not aid a patient in any way to receive PAD (Moulton, 2015, p. E426). This is a protection provided by the Canadian Medical

Protective Association (CMPA) (Moulton, 2015) and it will likely be a guarantee that some physicians find applicable to their own religious or personal ethics (p. E426). Finally, Wagner and Pearl (2016) infer from the *Carter v. Canada* decision that the Supreme Court did not rule that physicians must assist individuals in the act of assisted-dying, and that forcing physicians to even refer a patient to another that would assist in PAD would be against that individual's personal rights (p. 9). It may infringe on their own personal beliefs or their freedoms to have these beliefs (p. 9).

With these factors in mind, it is easier to understand the context of how PAD policy has been implemented; it also positions the discussion of policy in a way that indicates how many aspects are still in the beginning phases and that there are many questions left unanswered. The significance of every aspect listed above, among others, plays a key role in the implementation of PAD and will hopefully be addressed to create a thoroughly revised edition of the legislation that has been put into place.

***Carter v. Canada (Attorney General) (2015): The ruling that legalized assisted-dying***

In 2009, Gloria Taylor was diagnosed with ALS. With the prohibitive ban on assisted-dying, Taylor could not die on her own terms (*Carter v. Canada*, para. 12). In 2011, Taylor, Lee Carter (daughter of Kay Carter), Hollis Johnson (husband of Lee Carter) and Dr. William Shoichet, along with British Columbia Civil Liberties Association (BCCLA), set in motion a challenge to the blanket prohibition on assisted-dying (*Carter v. Canada*, 2015, para. 11). This challenge argued that all legislation prohibiting an assisted-death (s. 14 & 241 of the *Criminal Code*) was unconstitutional because it violates section 7 and 15(1) of the *Charter*. The plaintiffs in the *Carter* case made two claims:

(1) that the prohibition on physician-assisted dying deprives competent adults, who suffer a grievous and irremediable medical condition that causes the person to endure physical or psychological suffering that is intolerable to that person, of their right to life, liberty and security of the person under s. 7 of the *Charter*; and (2) that the prohibition deprives adults who are physically disabled of their right to equal treatment under s. 15 of the *Charter*. (*Carter v. Canada*, 2015, para. 41.)

In June 2012, the BC Supreme Court ruled that the assisted-dying prohibition did, in fact, violate Gloria Taylor's section 7 and section 15 rights and she was granted a constitutional exemption to receive an assisted death (*Carter v. British Columbia*, 2012). Justice Smith declared that the law was invalid and Parliament would need to enact legislation to fit the ruling. Gloria Taylor passed away in October 2012 of natural causes and did not use her constitutional exemption of an assisted death (CBC News, 2012). This decision was overturned in 2013 by the British Columbia Court of Appeal because of the principle of *stare decisis* because of the former decision *Rodriguez* (1993) (*Carter v. Canada*, 2015). The 2013 appeal was appealed to the Supreme Court of Canada (SCC). The SCC found that the Taylor's s. 7 rights were being violated by s. 241 of the *Criminal Code* (*Carter v. Canada*, 2015, para. 64). Preventing Taylor from receiving an assisted-death would contribute greatly to her suffering in the advanced stages of her condition and this would cause undue pain and suffering (*Carter v. Canada*, 2015, para. 66). In addition, other Canadian court decisions have addressed the importance of patient autonomy, medical decision making and the right to make 'fundamental life choices' (*Carter v. Canada*, 2015, para. 67-8); these cases (*Nancy B. v. Hôtel-Dieu de Québec*, 1992, *Ciarlariello v. Schacter*, 1993, among others) have examined the importance of consent and autonomous decision regarding one's bodily integrity—thus, "it is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued" (*Carter v. Canada*, 2015, para. 67). Taylor was deemed to be a competent adult requesting the right to an assisted-death on the basis that she did not wish to live

in a state of suffering. As per *Canada v. Bedford* (2013), the SCC found it to be important to determine what the purpose of the original law prohibiting assisted-dying was for, in order to protect vulnerable individuals from committing suicide during a weakened state (*Carter v. Canada*, 2015, para. 78). This was necessary to determine whether the prohibition was overbroad or grossly disproportionate. Identifying the original purpose of the law was crucial in understanding that former landmark decision *Rodriguez* identify the ‘preservation of life’ principle; this principle was deemed in *Carter* to be a “social value rather than as a description of the specific object of the prohibition” (*Carter v. Canada*, 2015, para. 76).

All three parts of s. 7 were engaged in the *Carter* case: ‘life, liberty and security of the person’ because the blanket prohibition impacted each interest. Gloria Taylor’s quality of life was impacted by the prohibition and create the possibility that she could take matters into her own hands while she was still able to. This would be detrimental to the intended purpose of the law, since it was meant to prevent suicide—not create it. Taylor’s liberty was impacted because she had the right to make autonomous decisions regarding her person, and not have this taken away by the government (*Carter v. Canada*, 2015, para. 30); a blanket prohibition on PAD took away her liberty because it disallowed her to engage in a dignified death of her choice. Finally, Gloria Taylor’s ‘security of the person’ right was engaged from prohibiting PAD because of the fact that she could not choose her death, and take care of her person (*Carter v. Canada*, 2015, para. 30).

The SCC ruled that the prohibitive ban on assisted dying infringed upon s. 7 rights, and that these infringements were not in accordance to the principles of fundamental justice (POFJ). It was overbroad in having an impact on individuals that do not fall under a vulnerable category. It is possible for individuals to be competent, rational and have a disability but still be capable of

making a choice to receive a medically assisted death (*Carter v. Canada*, 2015, para. 86).

Moreover, the ban was found to be grossly disproportionate to its original purpose because it may cause an individual to suffer unnecessarily. If individuals are not given the right to make the autonomous decision to die with dignity, it could cause an individual to take their own life while they are still able to—creating the possibility of a premature death (*Carter v. Canada*, 2015, para. 89-90).

The law was not found to be arbitrary in its nature because it fulfilled its purpose. The ban helped to prevent individuals from assisting in suicides, and from individuals receiving assisted-deaths, so it did fulfil its duties (*Carter v. Canada*, 2015, para. 83-84). In *Carter*, the ruling found that the s. 7 violation of the *Charter* could not be saved by s. 1 because the violation was not in accordance to the POFJ (*Carter v. Canada*, 2015, para. 31); under analysis, it was found that the law was overbroad since was meant to protect vulnerable populations but it impacted more than just those who were intended to be protected. Additionally, it was grossly disproportionate, due to the severity of the outcomes (*Carter v. Canada*, 2015, para. 31).

On February 6<sup>th</sup>, 2015, the SCC ruled that the blanket prohibition on assisted-dying violated the s. 7 rights of the *Charter*, and that s. 241 and 14 of the *Criminal Code* were not in accordance with the principles of fundamental justice. Section 15 did not need to be examined under the principle of fundamental justice because the law was found to be unconstitutional under s. 7 (*Carter v. Canada*, 2015, para. 93). The legislation was given a suspended declaration of invalidity for a 12-month period (*Carter v. Canada*, 2015, para. 147 & Nicol & Tiedemann, 2016, pp. 3-4).

### ***Bill C-14 (2016) Overview: A Legislative Background***

In June of 2016, the Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016) was published by the Department of Justice of Canada. This Legislative Background on MAID is a compilation of the history of the *Act* (Bill C-14, 2016) and the discussion of concerns and considerations with respect to policies in other countries. This legislative background gives in detail an explanation for each section in Bill C-14 (2016). The Legislative Background (2016) explains that Bill C-14 (2016) was enacted to: “find a balance between the autonomy of those individuals seeking access to medical assistance in dying and the interests of vulnerable persons and of society...” (Government of Canada, Legislative Background, MAID, 2016, p. 6). Even though Parliament recognized the possibility of impacting section 7 and 15 rights of the *Charter* by including the eligibility criteria that an individual must have a natural foreseeable death. This criterion is considered valid by legislators because it supposedly recognizes the importance of this balance that they sought to find while implementing this bill, and preserving the ‘respect for human life’:

“[*Restricted to Individuals whose Deaths have become Reasonably Foreseeable*] 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.” Moreover, this criterion was *meant* to be ambiguous—to allow medical practitioners to make a discretionary decision for each individual case (Government of Canada, Legislative Background, MAID, 2016, p. 21).

### ***Bill C-14 (2016) Medical Assistance in Dying***

Bill C-14: *An Act to Amend the Criminal Code and to make related amendments to other Acts* (2016) was first introduced to the House of Commons on April 14<sup>th</sup>, 2016 by the Minister of

Justice (Nicol & Tiedemann, 2016, p. 1). In the *Carter v. Canada* (2015) ruling, the government was given initially given 12 months to draft legislation that would fit the needs of society regarding assisted dying. This ended up being 16 months because the federal government filed a request for an extension, so the SCC granted an extension to the suspended declaration of invalidity (Nicol & Tiedemann, 2016, p. 1). The process of enacting this bill included the implementation of three panels to address important issues regarding MAID: The External Panel on Options for a Legislative Response to *Carter v. Canada*, A Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, and the Special Joint Committee on Physician Assisted Dying (Nicol & Tiedemann, 2016, pp. 1-2). In drafting the MAID legislation, Quebec's end of life legislation Bill 52: *An Act respecting end-of-life care* was examined. This examination involved addressing common similar issues as those being faced for legalizing assisted-dying across Canada. Some of these similarities are related to policy guidelines, rights of the patients and of those who are providing the MAID, as well as other issues (Nicol & Tiedemann, 2016, p. 3).

The Special Joint Committee on Physician-Assisted Dying (the Special Joint Committee) was created by the House of Commons and the Senate in December of 2015 (Nicol & Tiedemann, 2016). This committee produced the *Report of the Special Joint Committee on Physician-Assisted Dying* in late February of 2016. This report was published just months before Bill C-14 (2016) received royal assent and presented 21 expansive recommendations for policy makers to consider; three specific recommendations were overlooked that were of importance for the rights of Canadians.

The second recommendation given by the Special Joint Committee "That medical assistance in dying be available to individuals with terminal and non-terminal grievous and



irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition” (p. 45). This recommendation has been overlooked entirely within Bill C-14 (2016), unless an individual’s death is ‘reasonably foreseeable’ they will not meet the eligibility criteria. Recommendation number three provides that “That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition” (p. 45). Those with psychiatric conditions are not able to access assisted-dying at this time, however, there is an independent review in the works that will be published in the near future regarding how requests from mentally ill, mature minors, and even advanced requests will be implemented or ignored indefinitely within Canadian policy.

Recommendation number four recognizes that conditions that cause psychological and/or physical suffering should be a criterion, however, current policy does not really factor this in, since it mainly ignores the actual suffering part of an individual’s life (ignoring the importance of an individual’s quality of life), and frames policy around a ‘foreseeable death.’ Though an individual must be facing an irremediable and grievous condition, their death must be imminent, so their suffering is arguably disregarded; in plain terms, an individual that is going to die soon, that has a terminal illness can make the choice to die a little bit sooner, since they’re going to die anyway, but someone that is suffering intolerably, that doesn’t have an expiry death, is not allowed the privilege of having that autonomy over their own body. Downie (2016) in Ogilvie and Oliphant (2016) argues that terminal illness should not be a requirement within MAID policy, since it is a vague concept, “It is arbitrary and it has no moral justification as a barrier to access.” (Downie in Ogilvie & Oliphant, 2016 p. 12)

A person's death being 'reasonably foreseeable' is merely a safeguard and it is an attempt to prevent individuals from ending their life too soon. Preserving the concept of sanctity of life may coincide with the laws' original purpose of protecting those from being forced into an assisted-death. This safeguard is damaging to society because it leaves out individuals that do not fall under this category of a foreseeable death. In addition, imposing this to be an eligibility criteria has an impact on many of those terminally ill patients that may be facing a long life full of suffering, and so it takes away their autonomy over their own body, their dignity, and impacts their quality of life.

On June 15, 2016, the Bill was passed by a vote of 64-12 and sent back to the House of Commons (Tasker, 2016). There were seven amendments proposed including the removal of 'reasonably foreseeable' as a criterion to receive MAID, education on palliative care for those requesting MAID, the prevention of an individual being involved in the process/signing if they would benefit from a patient receiving MAID (family member), clarity for death certificates and medical practitioners, a two-year deadline for the independent reviews to be completed, and two amendments regarding the language used in the Bill (Clerk of the Senate, June 16, 2016, pp. 1-3).

By a vote of 44-28, on June 17, 2016, MAID became law. The House accepted some of the amendments provided by the Senate, including palliative care information and banning beneficiaries from being involved in any MAID processes (MacCharles, 2016). The House did not, however, remove the reasonably foreseeable death clause. Prime Minister Justin Trudeau stated that there was a necessary balance in the legislation—in doing so it would protect vulnerable populations without impacting *Charter* rights (Smith, 2016). Ultimately, the Senate backed down from demanding the removal of the reasonably foreseeable criterion, even though

many of the senators felt that keeping the clause in was arguably unconstitutional (Stone & Fine, 2016). Senator André Pratte said (in an interview) “I am convinced the government is making a serious and cruel mistake by taking away the right to medically assisted dying from a group of patients...but the government will answer to the people for that error. And hopefully, in the not too distant future, the courts will remedy that mistake” (Stone & Fine, 2016).

This is an interesting point made by Pratte, that he expects the courts will fix the mistake made by the government—which in part may be true as to identifying whether the new law is constitutional. Bill C-14 (2016)’s enactment is a representation of how policy makers and the government view society; they simply do not care if they create a law that will infringe upon the rights of many. Or have other political motives that come into play such as cost-effective factors. In addition, even if the law is challenged through the courts, it could take years to have a solid remedy, in which case if Parliament is forced to create or amend new legislation it could take even more time to meet the same prohibition model.

Bill C-14 (2016) amended the *Criminal Code*, specifically to sections 14, 227 and 241 (Bill C-14, 2016 & *Criminal Code of Canada*, 1985). These changes were implemented to create the legal exemption for MAID and to provide security for those physicians providing MAID, the pharmacists involved in dispensing the lethal dose, and other medical practitioners that are involved in the process to ensure that they are following the standards set out by Bill C-14 (2016). Bill C-14 (2016) has eligibility criteria and exemptions for those involved in the process. These criteria and exemptions are also outlined in section 241.2 (1) and (2) of the *Criminal Code*. Significant criteria to make note of are that individuals must be 18 years or older, competent to make decisions and have a ‘grievous and irremediable medical condition’ (p. 5, section 241.2 (1) (c)). In addition, individuals requesting MAID must be made aware of the

options available to them in Canada, and have made the request for MAID without feeling any pressures to do so (pp. 5-6) Bill C-14 (2016) goes on to define what a grievous and irremediable medical condition is, and declares that individuals must meet all the criteria to receive MAID.

Changes to the *Criminal Code* under section 241.2 (2) as amended by the implementation of Bill C-14 (2016) are:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining. (Bill C-14 1<sup>st</sup> reading 42<sup>nd</sup> parliament 2016)

Whether these criteria fit the needs of all of society, and whether the intentions of this law (those being equal access but still protecting those who may become vulnerable) are in fact being met by following these criteria will be examined later throughout this paper.

Bill C-14 (2016) also provides a list of safeguards and protocols for medical practitioners to follow while assessing if a patient meets the criteria of receiving a medically assisted death and presents guidelines to help the physician carry out the request. An important part to this criteria is that throughout the request process and before the medical assistance, the practitioner must remind the individual that they can change their minds at any time and ensure that the individual understands this (Bill C-14, 2016, section (3), pp. 6-7).

Bill C-14 (2016) gives explanations for extenuating circumstances, such as if an individual is unable to sign the form themselves (section 4), and there needs to be an independent witness during the process of MAID. There are extensive guidelines for an individual's

eligibility to partake in becoming an independent witness (section 5). Bill C-14 (2016) states that an independent witness is:

- (5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they
  - (a) 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;
  - (b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;
  - (c) are directly involved in providing health care services to the person making the request; or
  - (d) directly provide personal care to the person making the request.

These criteria for independent witness eligibility help to protect individuals requesting MAID and serve as a safeguard for those involved. There are also guidelines for the independence between independent witnesses (section 6). This is important to recognize because it helps to ensure that those involved in the witnessing process are not predisposed to any conflicts of interests, and neither are the medical practitioners or nurse practitioners. The medical practitioners and independent witnesses must be independent of one another to protect the patient's rights and their well-being.

There are other requirements set out by Bill C-14 (2016) such as that medical practitioners involved must have 'reasonable knowledge, care and skill' (section 7). This does not necessarily mean that there is specific training and education that must take place to provide MAID, but it does mean that individuals must follow guidelines set out by their location's standards or medical codes. Finally, there are consequences if the process of MAID is not up to the standards and guidelines that have been laid out in Bill C-14 (2016) and within the *Criminal Code*. Individuals that fail to comply with the laws set forth by s. 241 of the *Criminal Code* are liable to be convicted for their offence and may receive an indictable or summary conviction

depending on their offence. Bill C-14 directly states that MAID is not a service that is mandatory for all physicians to offer, but for those who do, they will be subjected to the consequences based on their failure to comply with the law. The fact that no medical practitioner is forced to participate in MAID is significant because it protects the rights of physicians. However, it also is related to the issue that institutions are also not forced to offer MAID. This aspect will be discussed later in the analysis portion of this paper.

### ***Independent Review and Bill C-14 (2016)***

Bill C-14 (2016) required the Minister of Justice and the Minister of Health to start an independent review within 180 days after Bill C-14 (2016) received Royal Assent. This independent review was initiated on December 13, 2016 and will address three of the widely-discussed elements: mature minors, advanced directives and the mentally ill (Bill C-14, section 9.1 (1) and (2), p. 13). The independent review “will gather and analyze relevant information and evidence on the diverse perspectives and issues surrounding requests for medical assistance in dying in these three areas, to facilitate an informed, evidence-based, dialogue among Canadians and decision-makers” (Health Canada, 2016, p. 30). The independent review is meant to provide recommendations and a report that can further be examined whether these three elements should be put into Canadian law regarding MAID and international perspectives will be addressed within this review (Health Canada, 2016, p. 30). Finally, this report will be made available for the public and for Parliament, and will be completed within two years. The expected publication date is December 2018 (Health Canada, 2016, p. 30).

### ***Provincial Policies***

The provincial policies and guidelines were derived from a report produced by the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (hereinafter P-T Group). This panel created by the federal government was meant to inform the policy and make recommendations that would help to implement assisted-dying lawfully throughout Canada (Nicol & Tiedemann, 2016, p. 2). This committee was created in August 2015 and did not include participation from Quebec because they have their own assisted-dying policy (Nicol & Tiedemann, 2016, p. 9). The final report was published and accessible on November 30, 2015. The advisory committee came up with 43 recommendations regarding the medical aspects of MAID, as well as accessibility, duty of the patient, research, oversight, faith based institutions, conscientiously objecting, reporting, assessments and other important aspects of assisted-dying (Gibson & Taylor, 2015). Once Bill C-14 (MAID) became law, these standards and guidelines regarding MAID were submitted to the Canadian Medical Association (CMA), as well as the Federation of Medical Regulatory Authorities of Canada (FMRAC). One of the requirements of Bill C-14 (2016) was for the Minister of Health to work with the provinces and territories to create regulatory guidelines regarding MAID (Legislative Background: Medical Assistance in Dying, 2016). In addition, these guidelines were meant to be consistent across Canada and were subject to the core elements of the *Canada Health Act* (Legislative Background: Medical Assistance in Dying, 2016).

The College of Physicians and Surgeons of each province issued the guidelines and standards regarding MAID. Each report was published shortly after Bill C-14 and provides detailed information regarding the eligibility criteria to receive assisted-death, and gives a

summary of *Carter v. Canada* (2015) and how a medical practitioner should go about providing MAID.

### *Process*

The process of receiving MAID is similarly regulated throughout the provinces of Canada, some policies being more detailed than others. Throughout the country, a consistent requirement for the process of MAID is that there must be two “medical assessors” (College of Physicians and Surgeons, British Columbia, 2016, p. 2). These medical assessors provide their assessment of a patient, and then depending on their assessment, MAID may be carried out. Medical assessors must be a registered nurse or physician to meet the criteria of becoming a medical assessor. There are a few other strict criteria for a physician or nurse to become a medical assessor. Importantly, medical assessors must be independent of one another, so that there is objectivity (College of Physicians and Surgeons, British Columbia, 2016, p. 3). A medical assessor is independent if they are:

- a. are not a mentor to the other MA or responsible for supervising their work
- b. do 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, other than standard compensation for their services relating to the request
- c. do not know or believe that they are connected to the other MA or to the person making the request in any other way that would affect their objectivity (Professional Standards and Guidelines – Medical Assistance in Dying, British Columbia, June 23, 2016).

Another aspect of the process is that individuals that are requesting MAID must be deemed competent and able to give personal consent to such a request. A pharmacist will dispense the medication to the physician’s possession in the patient’s name. Patients must be reminded that they can rescind their request at any time. Physicians must be present during the entire procedure



of administering or transferring the medication to the patient and must not leave the patient until they have been pronounced dead (College of Physicians and Surgeons, British Columbia, 2016, p. 4). A medical assessor that carries out the MAID must complete a MAID Report of death form. This may specifically be sent to each provinces' Coroner service, or to whichever organization that reviews said forms.

### ***Documentation***

Documentation is created when individuals request MAID and for those individuals who are unable to sign said documentation, a competent adult may do so on behalf of the individual requesting, so long as they are not benefiting from such a request, and it must be with the request of the patient that is unable to sign (College of Physicians and Surgeons, British Columbia, 2016, p. 5). This documented request must be witnessed by two independent individuals that are competent adults. There are a few criteria that outline whether an individual is an independent party. This is important because there are factors that may cause conflicts in such a situation, and the criteria that an independent witness must face are righteously put into place to protect those who may request MAID, and prevent an individual from receiving MAID in cases where they may be coerced into doing so.

### ***Conscientious Objection***

A conscientious objection may occur where a medical practitioner objects to offering MAID for their own personal reasons. This may be because of their own personal beliefs, such as a religion or an objection to its morality, or because of some type of conflict of interest—such as a personal relationship with the individual. If this is the case, physicians are subjected to the *Professional Obligations and Human Rights* (2008) policy. They are expected to inform their

patients of their reasons, and not disregard the patient's needs; this means that they could assist them in finding a physician that is able to assist them in MAID if that is what they choose. They are not, however, permitted to disregard the availability or option of MAID. With these factors to be taken into consideration, medical practitioners are not being forced to offer MAID in their practices. The legislation, and the College of Physicians and Surgeons, does not expect all practicing physicians to offer MAID (College of Physicians and Surgeons of Ontario, 2016, p. 5).

This concept of conscientious objection provides patients with security, knowing that their needs will be heard and assessed, but also provides safeguards for medical practitioners who simply do not wish to partake, or who have moral or religious beliefs that may otherwise prevent them from offering this end of life assistance. The intent of the policy was to protect all parties involved, therefore, conscientious objection provides a useful and practical option, which nevertheless helps to ensure that the rights of physicians are not being impinged upon. A concern for many medical practitioners as noted by the CMA was that some may be forced to offer MAID, so conscientious objection creates a safeguard for medical practitioners. This is a key issue in the MAID debate currently because it is having an impact on the accessibility and ease of access to MAID for patients wishing to receive it (Dying with Dignity, 2016). No medical practitioner is forced to offer MAID, and neither are any medical institutions. This includes palliative care units, hospitals, hospices and religious health facilities. This has become an issue because an institution's refusal to offer MAID is creating a barrier for those wishing to access it, but also forcing them to seek treatment outside of a facility and causing unnecessary suffering.

***The Federation of Medical Regulatory Authorities of Canada (FMRAC)***

Another important organization involved in MAID is the Federation of Medical Regulatory Authorities of Canada (FMRAC). FMRAC is an organization that helps to encourage the collaboration of the members on important medical policy regulation. It also helps to create standards and inform parliamentary bodies of important medical issues (FMRAC, 2016). The members of FMRAC are the 13 Provincial and being a Colleges of Physicians and Surgeons as per whichever province or territory they belong to (FMRAC, 2016). FMRAC policy recommendations are founded on eight principles. It is important to recognize these eight principles while reviewing the provincial policies and processes regarding MAID, since ultimately, if the policies set in place to help guide medical practitioners are not following or in accordance to these principles, then it is possible that patient's rights, or the rights of some medical practitioners are being overlooked. If one were to use these eight principles as a guide while reviewing provincial policies, one can determine whether these principles are being used and applied correctly. Although Bill C-14 (2016) set out eligibility criteria for those who are legally allowed to receive MAID, and provided definitions (though minimally), it has been left up to the provinces to put orders into effect to educate, assist and guide the implementation of MAID across Canada. Therefore, these principles are and have been considered in provincially documentation.

The eight principles are:

1. Respect for patient autonomy—meaning that those who are competent adults can make autonomous decisions about their person
2. equity—meaning that those who wish to receive an assisted death are able to access information and access to this right should they meet the criteria
3. respect for physician values—meaning that physicians involved may be allowed to have their own personal beliefs and must practice without discriminating; as well as following their code of ethics
4. consent and capacity—meaning that the required criteria are met, and voluntary consent is given

5. clarity—meaning that all methods used by physicians and medical bodies must be clear for patients to understand and express the duties of the medical practitioner,
6. dignity—meaning that everyone involved in the process must be treated with dignity
7. accountability—meaning that those who are involved must ensure that they are capable in conducting assessments and when they are in need of help in difficult decisions, that they consult with their superiors
8. duty to provide care—meaning that physicians must not abandon their patients and must ensure that the patient has another medical practitioner unless they are no longer needed, and that they must be helpful and show compassion to their patients (FMRAC, Physician-Assisted Dying Guidance Document, 2016, p. 2).

These principles are representative of the values that FMRAC encourages. This is relevant because it illustrates the need for consistent regulatory bodies—and so at least on the surface, these eight principles are useful in analyzing Bill C-14 (2016)’s acknowledgement of these principles.

### ***Julia Lamb and the British Columbia Civil Liberties Association***

Shortly after Bill C-14’s (2016) enactment, Julia Lamb and the British Columbia Civil Liberties Association (BCCLA) put in motion a civil claim regarding her case. Julia Lamb suffers from a grievous and irremediable medical condition that causes intolerable suffering (para. 6-7), but her death is not necessarily reasonably foreseeable, since the condition which she suffers from (Spinal Muscular Atrophy, SMA) has varying progress and is classified as a ‘progressive degenerative disease’. Individuals that suffer from this degenerative disease have a lower life expectancy and it is incurable (para. 8-10). Lamb suffers from other health complications arising because of her disease, but it does not impact her cognitive abilities (para. 9). Bill C-14’s (2016) eligibility criteria prevents her from requesting MAID. The remedy that this civil claim is seeking is a declaration of invalidity and that Julia Lamb be provided with a constitutional exemption when she feels that the state she is living with becomes intolerable (p. 11). This is on the grounds that her section 15 (1) *Charter* rights are being infringed upon

because the law is discriminatory against her because of her disability and she is not allowed the same equal benefit of the law (p. 13). Lamb is arguing that her section 7 *Charter* rights are being infringed upon since Lamb is unable to use MAID to decide to end her life. So, her liberty is being infringed upon if she cannot make this autonomous decision because of the law. This law is causing her to suffer intolerably and so her fundamental right to security of the person is being deprived (Notice of Civil Claim, BCCLA, Lamb, 2016, para 10-12). Because of her condition, the civil claim argues that the law prevents individuals that not in the typical age range of a person suffering intolerably to receive an assisted death in a lawful way, and prevents those who are unable to take their own life. In addition, the civil claim seeks to challenge the constitutional validity of section 241 of the *Criminal Code* because Bill C-14 section 241 (2) part (b) and (d) state that an individual meets the criteria to receive an assisted death, only if they are in ‘irreversible decline’ and ‘their natural death has become reasonably foreseeable’ (p. 3, para. 5).

The Attorney General of Canada responded to the BCCLA’s civil claim by stating that section 241.2 of the Criminal code is “a reasonable limit under s. 1 of the *Charter*” (Attorney General of Canada, Response to Civil Claim, 2016, p. 9); it responds that the sections provided do not infringe upon the *Charter* rights (section 7 or 15 (1)). The response to the civil claim makes note of the importance of suicide prevention and argues that it maintains that stance by continuing to follow the laws set out (Response to Civil Claim, Attorney General, p. 8. para. 10). It is also argued within this response to the civil claim that the *Carter* (2015) ruling did not “provide a general right to medically assisted death as a response to suffering in life” (Response to Civil Claim, Attorney General, 2016, p. 8, para. 9).

### ***Dying with Dignity Canada***

A significant organization that has been involved in the ongoing compilation of research and data, as well as advocating for assisted-dying in Canada, is Dying with Dignity Canada (DWD). This organization was included within this data because one of the interview participants works with DWD. They are a significant organization advocating for MAID and the rights of those who wish to receive MAID because they help to educate the public on the rights that Canadians currently have, allow individuals to input their concerns about end-of-life options, and help to inform individuals where they can reach out for end-of-life options. DWD was founded on June 1<sup>st</sup>, 1980, and is a non-profit organization that advocates for end-of-life options such as MAID within Canada. They have also been consulted with on panels, such as the *Report of the Special Joint Committee on PAD* (Ogilvie & Oliphant, 2016). DWD has expressed their main concerns and recommendations for policy regarding MAID. These three recommendations are: “safeguards should be reasonable but not excessive...non-participating physicians and pharmacists must provide effective referrals...patients need to be able to die wherever they live” (Dying with Dignity Canada, 2015). These are important aspects of the MAID framework in Canada and since Bill C-14 became law in June 2016, two of these concerns have been arguably addressed within the legislation. The safeguards for those who are vulnerable can be seen by the provincial policies and resources enacted throughout the provinces to ensure that an individual’s competence is acceptable is already a part of the framework. Physicians may refuse to help their patients in ending their lives through PAD, but they still must support their patient by referring them to another physician that does offer MAID. However, the last recommendation is most concerning, because across Canada it has been seen that some hospitals and end of life care units are refusing assisted-dying within their facilities; this creates a cruel alternative to those wishing to access PAD—they must be transferred out of these facilities to have their appointments and

the assistance in death (Dying with Dignity Canada, 2016). This is cruel to those who are suffering from grievous and terminal illnesses—especially if they meet all the criteria set out by Bill C-14. Although Bill C-14 does not force medical practitioners or specific institutions to aid in death, it is arguably unjust that if MAID is now law in Canada that individuals are unable to access their right in any institution that is funded publicly. Conscientious objection is specific to physicians and medical practitioners, but it does not prevent those who do not object to MAID from coming to these institutions and helping a patient that has been referred to them, and so transferring these individuals for their assessments regarding MAID and the actual act of PAD is arguably detrimental to their security of their person, when they already have the right to choose to die with dignity. St. Paul's Hospital located in Vancouver, British Columbia is one facility specifically that has refused assisted death on the premises. This has become an accessibility issue for those patients requesting MAID (Blackwell, 2016).

### *Chapter 3*

#### *Interview Findings & the Implications of Bill C-14 (2016)*

The interview portion of this project helped to supplement the policy analysis. The participants were all required to be 18 years or older and involved in the MAID debate already to ensure that they were no risks created by their participation in the research. This group was targeted because these individuals were not an at-risk population or receiving MAID themselves. The sampling method used was purposive, but also turned into a convenience sample because participants had to fit the criteria and be able and willing to participate in an interview. These interviews were one-on-one and audio recordings were used to ensure accuracy of the information and were transcribed after the interview ended.

Semi-structured interviews were the most efficient form of interviews that could be conducted in this research to include the knowledgeable opinion of the individual that was chosen and willing to participate. Semi-structured interviews allowed for the conversations to flow naturally and allowed the direction of the conversation to adapt to new concepts that I did not bring up, but, it was still feasible to keep the conversation on topic and directed to the concepts that were relevant to this project. The questions I had for participants were asking about policy recommendations, how the policy is working in practice, what is vulnerability, and the ‘reasonably foreseeable’ criteria that Bill C-14 (2016) entails. These questions are important because they are not directly resolved in policy or law; they are often open to interpretation and so the dialogue that was created in these interviews helped to broaden and inform the research in a very rich way. This research was meant to be exploratory, and it did explore new ideas and aspects of assisted-dying that I did not foresee. The interviews conducted were one-on-one between myself and the research participant; the interviews lasted up to an hour in length and were completely voluntary.

Two interviews were conducted for this research project. These interviews were conducted via Skype and telephone. The first interview was with Dr. Ellen Wiebe from the University of BC (UBC). Dr. Wiebe is a physician in British Columbia that offers MAID, and is a member of the Physicians Advisory Council of Dying with Dignity Canada. Wiebe provided great clarity and insight into the process of MAID and some methods of making this process easier. She also provided insight to the difficulty of defining vulnerability and determining vulnerability in those that are requesting MAID. The second interview conducted was with Cory Ruf, the communications coordinator of Dying with Dignity Canada. Ruf illuminated that it is important to look at eligibility criteria and safeguards as two separate categories. Ruf noted that under Bill



C-14 (2016), individuals that have the capacity to make a request to MAID, but do not have a ‘reasonably foreseeable’ death are unable to receive MAID, and are forced to endure intolerable suffering. Both interviews identified some key issues with Bill C-14 (2016) and aspects of policy that still need to be addressed. The key themes from these interviews were identified by understanding the direction of both interviews and recognizing the issues that literature already produced may not have explored as thoroughly. The key themes identified were: vulnerability, recommendations to policy, independent reviews, reasonably foreseeable death and understanding safeguards.

### ***Vulnerability***

A finding that was interesting to this research was that in one physician’s perspective, determining whether an individual is vulnerable is not a difficult assessment to make. There are factors that must be considered while determining vulnerability, such as if an individual may be easily persuaded to request an assisted-death. Dr. Wiebe notes that individuals in a vulnerable state are “usually so obvious that you don’t need to [assess them]. But the kind of people who ask for assisted deaths tend to be white, rich, well-educated, very much in charge of their lives and that’s why they want to be in charge of their deaths” (E. Wiebe, personal interview, February 7, 2017). An important aspect of recognizing vulnerability is to understand if an individual can give informed consent, and able to understand what their end-of-life options are and make informed decisions based on that understanding. There are many psychosocial factors to be considered, especially the fact that deeming an individual to be vulnerable, does not necessarily mean that an individual cannot give informed consent or request an assisted-death (C. Ruf, personal interview, March 13, 2017). This illustrates the fact that vulnerability cannot easily be defined, but in terms of medical assistance in dying, it is up to the physician to make that

determination to ensure the safety of those requesting end-of-life options. Dr. Wiebe addressed the fact that there are individuals living in vulnerable situations, as well as vulnerable populations and those that are living with conditions that may arguably make them vulnerable so it is important to understand this differentiation and make assessments accordingly (E. Wiebe, personal interview, February 7, 2017). Wiebe addresses the questions regarding how to define vulnerability by introducing her own interests in vulnerable populations which really illustrates the dynamics of vulnerability. Some of the vulnerable populations as determined by various criteria that Wiebe makes note of are: Indigenous individuals, those in poverty and individuals that are incarcerated. An interesting finding that Dr. Wiebe shared was that many individuals living in these vulnerable situations are not thinking about a good death because they are living in ‘survival mode’ (E. Wiebe, personal interview, February 7, 2017). These people are vulnerable especially, and a question posed by Dr. Wiebe was: would they be considering an assisted-death if they were not facing or living in these conditions of vulnerability? (E. Wiebe, personal interview, February 7, 2017).

Ruf explains that those that are considered vulnerable are being “denied choice because they’re interpreted as vulnerable. Their agency is taken away from [them] even though they satisfy all the criteria. They are suffering intolerably and capable of consenting and understanding the consequences of their decision... Bill C-14 [shows] that there are groups that are being denied because Parliament is not acknowledging the agency that they have the right that they’ve been given and they’re being discriminated against because their death is not reasonably foreseeable for example on the basis of their diagnosis” (C. Ruf, personal interview, March 13, 2017).

### ***Recommendations to Policy & Independent Reviews***

A key finding throughout the interviews was that current policy is not fitting the needs of those requesting assisted-dying. Although a portion of these requests are related to advanced consent, mature minors and the mentally ill, an important factor that could be addressed before the independent reviews are completed is ending the process of transferring patients and making end-of-life options such as MAID accessible. There are many individuals suffering because they are seeking care in religious health facilities that do not provide MAID. This is a cruel and unethical treatment plan by forcing these individuals to transfer somewhere else in their end-of-life stages of suffering (E. Wiebe, personal interview, February 7, 2017). For assessments to be completed for those in publicly funded institutions refusing MAID, an individual may not even be aware that they have the option to request MAID. Individuals that are aware, and competent enough to make the informed decision, are forced to be transferred out of the institution more than once to complete the entire process of the request, assessment and decision making process.

Another factor that ties in with transferring patients is that requesting MAID is often a time sensitive matter, as some individuals are on the verge of losing their capacity or must refrain from taking pain medications to competently make decisions regarding their health. The possible delay of a transfer to receive MAID could go against the wishes of the patient if they lose their capacity before the transfer. This is related to the advanced consent concerns because if there was policy allowing an advanced request, then the wishes of the patient could be fulfilled even if they lost their capacity in that short period of time (C. Ruf, personal interview, March 13, 2017). Ruf notes that “publicly funded institutions are agreeing to transfer patients but in some cases the delay deprives them of their choice and the whole process imposes additionally pain and uncertainty and is certainly medically unnecessary and in our opinion inhumane” (C. Ruf, personal interview, March 13, 2017). Ultimately, there needs to be a balance between protecting

those that lose capacity but also fulfilling their autonomous decisions while they are able—thus, allowing a dignified death. Wiebe does not think that advance directives will become law in Canada, simply because there is “nowhere in the world can you say when I can no longer make decisions for myself I would like to have an assisted death” (E. Wiebe, personal interview, February 7, 2017).

Wiebe notes that that at the most, those who are requesting and receiving an assisted-death in Canada are around 5% of the population and so 95% of the others are dying naturally and not choosing assisted-dying (E. Wiebe, personal interview, February 7, 2017).

### ***Reasonably Foreseeable Death***

Dr. Wiebe identified that it is important to understand that it is difficult to predict an individual's death, so it is up to two independent doctors' assessments and discretion to decide whether their natural death is reasonably foreseeable. She also explains that there are varying answers when interpreting what 'reasonably foreseeable' means and that some physicians like herself believe that a few years can be interpreted within that criterion, while others believe that it must be within a couple of weeks, or even months. Ruf explains that it is questionable whether the reasonably foreseeable criteria complies with the *Carter* ruling and that “how reasonably foreseeable is interpreted... [could impact] someone with an excruciating chronic illness who could live for years or more than a decade in this condition of intolerable suffering...has the capacity to make that particular decision” (C. Ruf, personal interview, March 13, 2017).

It became apparent within the interviews that this criterion is being navigated on a case by case basis, based on varying factors such as life expectancy of the patient with their disease, and

their age as based on the life-expectancy of the average man or woman (E. Wiebe, personal interview, February 7, 2017).

### *Understanding Safeguards*

Physicians offering MAID such as Dr. Ellen Wiebe believe that Bill C-14 (2016) is a good one because it requires a “careful, thoughtful process” as well as a lot of time and energy (E. Wiebe, personal interview, February 7, 2017). Safeguards include 14 pages of forms that must be completed for each individual patient. There is also a mentoring process for those medical practitioners wishing to offer MAID. Cory Ruf of Dying with Dignity Canada explains that it is important to look at eligibility criteria and safeguards as two separate categories. He states that “we tend to link the safeguards and eligibility as the same thing [and] that there are ways that the eligibility serves as safeguards.” He explains that Bill C-14 (2016) controls who can access MAID by the eligibility criteria but also by using the safeguards such as two independent health care professionals being involved to evaluate a patient (C. Ruf, personal interview, March 13, 2017). An interesting factor related to this is that mature minors are left out of policy, simply because of their age. However, mature minors that have met the age of majority in most of the provincial territorial jurisdictions in Canada are able to make health decisions on their own and so this safeguard disallowing mature minors to request an assisted-death is arguably discriminatory (C. Ruf, personal interview, March 13, 2017).

These two perspectives are unique because they differ in opinions on the policy. Dr. Wiebe agrees that the policy could be better and noted that the documentation process is lengthy but that it ensures that the patients accessing MAID qualify under the law (E. Wiebe, personal interview, February 7, 2017). However, Dr. Wiebe thinks that “Canadians in general can be

reassured that it's a very good process" (E. Wiebe, personal interview, February 7, 2017). The important thing to take from this is that medical practitioners are doing their job to the best of their ability with the policy that they have been provided with. The issues with the policy are not in the application of MAID but in the policy, itself; Wiebe makes note of this with the recommendation of transferring patients (E. Wiebe, personal interview, February 7, 2017). Dr. Wiebe explains that Canadians need not worry about the process because the medical practitioners involved in MAID are doing the best they can to ensure that those who may be vulnerable are assessed individually and accordingly so that they are protected from being coerced to ending their lives. On the other hand, Cory Ruf makes note that though Bill C-14 (2016) did legalize assisted-dying, it does so "more conservatively, and more limited than those outlined in *Carter v. Canada* (2015) decision so those individuals that would have had access under the *Carter* decision now found that the right has been taken away from them under Bill C-14 (2016)" (C. Ruf, personal interview, March 13, 2017). This comment illustrates the main issue with assisted-dying policy in Canada because the *Carter* decision allowed competent adults to request MAID, but Bill C-14 (2016) takes away this right and limits it to those who fit the criteria that they must be in irreversible decline, and that they have a natural foreseeable death. It is shown in both perspectives that there is a need for a balance of allowing access to MAID but also protecting individuals from falling vulnerable to this policy.

## *Chapter 4*

### *Literature Review*

This literature review seeks to examine and connect literature from perspectives that are useful in examining policy in Canada that are related to assisted-dying. After this discussion, the literature review will explain what disability studies are and what the three paradigms within it are useful for, and how disability studies are significant. The approaches used are the vulnerability theory and the capabilities approach. These theoretical frameworks are useful in positioning where there are gaps in the literature, as well as where policy may be arguably damaging to many Canadians. It is important to examine these perspectives since assisted-dying legislation is not accessible to those who are vulnerable within society, and this review seeks to explore the concept of vulnerability and disability to help inform the discussion. Nevertheless, the purpose of the laws on assisted-dying is consistent with the theme that they have strict guidelines to protect the vulnerable, therefore, the benefits of examining this literature will be that the perspectives examined will help to inform the assisted-dying debate and hopefully be a guide to explain why it is necessary for there to be a balance between vulnerability and accessibility within Canadian policy.

While it is important to understand the legal aspect of the policy and decision behind the legalization of assisted-dying, it is also necessary to examine some theories that may be relevant and useful in making policy become applicable to society and accessible to all. The examination of vulnerability and disability are crucial to explain so that these individuals can have equal rights and to inform policy makers that there are ways in which the policy currently implemented overlooks those who may be suffering grievously but whose death is not imminent. Some important terminology to be familiar with for the following sections are disability and

impairment. Although there is not strictly one correct term for either of these words, the terms used for this particular literature review are as follows: a disability is defined as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (United Nations, in Wendell 1989, in Davis, 2006, p. 244). While impairment is defined as: “any loss or abnormality of psychological, physiological, or anatomical structure or function” (United Nations, in Wendell 1989, in Davis, 2006, p. 244).

### ***Vulnerability and Capabilities: Approaches used within Disability Studies***

Vulnerability is argued by Martha Fineman (2010) to be an inescapable part of living and impacts some populations more so than others. However, vulnerability is not harmful to society because society’s foundation and perspective of vulnerability is what is harmful to individuals facing vulnerability. Vulnerability does not just affect one single group such as a race or ethnicity—it plays a role in each member of society’s day to day life, and it may eventually impact an individual more so than they are accustomed to. Lid (2015) notes that “one obvious tension in discussing vulnerability and disability together is that people with disabilities have been treated as containers of vulnerability” (p. 1563). Vulnerability theory and disability studies are useful within this literature review because they help to explain the aspects of society that can be inquired upon, seeking out an understanding of those facing vulnerability, disability, impairments---and the importance of dignity and autonomy. For example, an individual may be able to live their life for years on end without any physical pain, until one day they begin to realize they are suffering from pains that continually worsen, thus becoming vulnerable because of their pain. They are unable to do the things that they used to do before they felt the pain originally. The pain that they are feeling is ingrained in their life and becomes a vulnerability—



one that may be fixed with certain pain medications or treatments, but never gone fully, except until death. Frazee (2003) illuminates this further by addressing the fact that those with disabilities may feel excluded in everyday circumstances, since their impairment makes it difficult to access certain parts of life without special adaptations to their surroundings (p. 260). Since individuals with disabilities face discriminatory aspects of life and are therefore excluded from opportunities that an able-bodied person would otherwise access, it makes disability studies and the lived experiences of disabled persons especially important to analyze because it could help to frame the future of inclusive policies (Lid, 2015, p. 1555). Additionally, the Society for Disability Studies (1993) explains that:

“disability studies [seeks] to disentangle impairments from myth, ideology, and stigma that influence social interaction and social policy...[and] seeks to uproot the idea that economic and social statuses and the assigned roles of [disabled people] are inevitable outcomes of their [impairments]” (Linton et al. 1994, in Frazee, 2003, p. 258).

Couser (2005) positions disability as a concept that creates many ethical considerations because individuals that are disabled become vulnerable when the individuality of disability is removed (p. 20). This means that when one individual is representing a group in its entirety, it can contribute to a distortion to what these individuals may need (p. 20). When disabled persons advocate for themselves, Couser (2005) states that they become less vulnerable because they are influencing how others perceive them by helping to create awareness about their conditions, and how they live and fit into society (p. 20).

Although it can be beneficial for advocates to be those who self-identify with disability, using only one individual as a representative takes away from many individual perspectives. Still, the possibility of a disabled person to become involuntarily represented is high, because there are many different advocacy groups for different disabilities. Therefore they can be

misrepresented, since these individuals leading these groups may not be generalizable to all of those who are being represented (Couser, 2005, p. 21). Furthermore, this is an ethical consideration to be contemplated while examining disability and policy, and Couser (2005) poses the question perfectly: “How can we guarantee or at least try to ensure, that representation serves the best interests of vulnerable subjects generally?” (p. 21). Law and policy has previously used ‘blanket prohibition’ techniques to guarantee just that. In terms of PAD policy, this was certainly the case for the ban of assisted-dying, since it did not allow for any one individual to fall vulnerable to the possibility of being misrepresented.

Moreover, disabled persons could be considered to be ‘vulnerable bodies’ since under some circumstances they may be unable to give consent to specific aspects of life and while considering assisted-dying laws, it is important to understand that the prohibition’s intention was to protect vulnerable people from receiving PAD without consent. Couser (2005) contrasts the terms impairment and disability by explaining that disabilities are the reaction to an impairment, an impairment being a function of the body that is anomalous, such as being deaf, blind, or paralyzed—or to have a deficit of the mind (p. 26); moreover, the reaction to any impairment is socially constructed and can nevertheless create tensions between the able-bodied and the disabled bodied (p. 26).

### ***Disability Studies***

According to Couser (2005) there are three paradigms within disability studies. Couser labels them as: symbolic paradigm, medical paradigm and the social paradigm (p. 22). These three paradigms are significant to disability studies because they can be applied to the question of how to represent disabled persons. The symbolic paradigm “makes a particular trait...the

master status...reducing their complex humanity into a single dimension. In representing one such individual, it characterizes them all” (Couser, 2005, p. 23) The medical paradigm seeks to explain that disability is meant to be removed by medical treatment, to move away from anything other than ordinary. But, it also theoretically takes away an individual’s disability by fixing it, so then it is removing their ownership of their disability. This means that an individual with an abnormality is not responsible for it (Couser, 2005, p. 24). The social paradigm is a combination of the previous two, but also adds to them; it does so by recognizing that disability is a socially constructed concept. Couser (2005) argues that disabled persons are ‘disempowered’ (p. 26) and so it “places the burden on society to accommodate anomalous bodies” (Couser, 2005, p. 26). The social paradigm can help disabled persons because it is useful for advocacy attempts (p. 26), meaning that more recognition to the experiences of disabled persons is impacted by the social construction (p. 26). Moreover, how disabled individuals are treated is the result of the social construction, in which case it is arguably exclusionary and creates unnecessary limitations to their lives and it ultimately seeks to marginalize and oppress those who are disabled (Couser, 2005, p. 26). For policy, Couser’s (2005) argument that disability needs to be better understood to ‘acknowledge’ and ‘accommodate’ the needs of those who are impaired (p. 28), and so he suggests that by using the social paradigm in disability studies, it can help to create a positive representation of disabled groups and dismember the normalcy of society that predisposes the disabled to become vulnerable bodies (Couser, 2005, p. 28). This is a useful paradigm to use while examining law and policy on assisted-dying since the next step could be making PAD accessible to those with disabilities that do not meet the current criteria.

The next few sections will focus on addressing key points of Martha Fineman’s Vulnerability Theory and address some limitations and analyses of the theory; in addition, it will

explore how vulnerability may impact a variety of different groups within society. The importance of understanding these views on vulnerability specifically will impact the outlook on vulnerable states and access to end of life care, such as physician-assisted dying (PAD). Moreover, equality, autonomy, and dignity are all key factors in determining and understanding what it means to be vulnerable (Lid, 2015, p. 1558). This is important to address since the examination of these constructs may be helpful in order to analyze that individuals that are vulnerable may have trouble gaining access to rights, and as some who are in vulnerable states may feel that it is "...the most basic of all rights, namely [is] the right to have rights" (Lid, 2015, p. 1561); in other words, their inability to access the right to have rights may seem as inescapable as their vulnerability itself, and it is important that there are individuals that seek to advocate and protect those who self-identify as vulnerable.

### *Understanding Fineman's Vulnerability Theory*

To begin, Fineman (2010) explains that the current way of approaching universal inequalities is setting specific groups against each other (p. 253), and that the subject of vulnerability is embodied within human rights movements (p. 255). In addition, Fineman (2010) takes the position that the government should be more responsive and receptive to the 'vulnerable subjects' of society, and that by doing so, it will create awareness for those facing inequalities (p. 274). Moreover, she argues that though self-determination is an important element that individuals should strive for, autonomous decision making in a society that is unresponsive is simply not possible (Fineman, 2010, p. 260). Fineman (2010) critiques the concept of liberalism, because she does not believe that it is applicable to 'vulnerable subjects' and that liberalism has socially constructed what equality is, and how it can be visible within society (p. 262). She explains that "competence is assumed and differences in power,

circumstances, or actual ability are ignored. Thus constructed, this ‘liberal subject’ is at the heart of political and legal thought” (Fineman, 2010, p. 263). This argument lays the groundwork to understanding that society is built on a system that is acknowledging many vulnerable groups without responding to their state of vulnerability (p. 255-56). Additionally, this means that society’s leaders and government organizations will need to be held accountable, to protect and include all the individuals that are living a vulnerable life (p. 256). In recognizing these key aspects of Fineman’s (2010) argument, it is important to rationalize who it is that is actually vulnerable, or living in a state of vulnerability and how society can address and be inclusive for those who are deemed ‘vulnerable.’ Fineman (2010) explains that “the term vulnerable population has an air of victimhood, deprivation, dependency or pathology attached to it” (p. 266) and this is likely what developed her four elements to approach vulnerability.

In Fineman’s *The Vulnerable Subject and the Responsive State* (2010), she provides four elements to understand her approach on vulnerability; these are framed and shortened by Cooper (2015), who presents them as: “universality, constancy, complexity, and particularity” (p. 1357). These components of vulnerability ultimately argued by Fineman (2010) mean that individuals among society will always face vulnerability, and that we cannot eliminate it entirely (p. 269), instead we must accept those who are facing vulnerabilities and expose the institutions and governments that are simply not being inclusive of those who are considered to be vulnerable. Again, it especially important to those who are vulnerable.

Fineman (2010) argues that equality is hard to accomplish when there is an abundance of individuals facing injustices, without the ability to access the same resources as many others within society; the “government is unresponsive to those who are disadvantaged, blaming individuals for their situation and ignoring the inequities woven into the systems in which we all

mired” (Fineman, 2010, p. 257). Moreover, an assumption that can be made is that equality and autonomy are connected, since there cannot be a real equality of humanity if autonomy is only possible for some parts of society (p. 256 & 259). This means that some parts of the population may be able to access services freely, without issues, so they see equality and are subjected to it; however, others that may be facing a more disadvantaged lifestyle may not be able to gain access to some services, so they are not being treated equally—thus not able to live an autonomous life. Ultimately, Fineman (2010) is arguing that vulnerability is an aspect of life that we may all experience (Fineman, 2010, p. 268; Cooper, 2015, p. 1357). This begins the unravelling of the universality of vulnerability, and how it can impact every person individually—directly or indirectly. This universality could be interpreted as linked to the drive for equality, since it seems that Fineman (2010) is attempting to connect the two and make vulnerability be applicable to everyone (Cooper, 2015, p. 1357); there are connections here to autonomy too, since those individuals who are facing disadvantages are less likely to be able to control and hold their own autonomy and thus fall vulnerable to society’s foundation of inequalities and injustices—forcing them to become dependent on the systems that are failing them to begin with (Fineman, 2010, p. 258). This is arguably related to the need for equality, and it is unlikely that society will be provided with equal opportunities, so it is even more doubtful that all individuals within society will succeed in achieving autonomy.

The second element of Fineman’s (2010) vulnerability theory is constancy, which frames society as individuals that are dependent on one another (Cooper, 2015, p. 1358). Fineman (2010) critically notes that vulnerability is constant because there is a “constant possibility of harm” (Cooper, 2015, p. 1358); therefore, dependency is a part of vulnerability, since if we are constantly vulnerable or subject to being harmed, we are arguably dependent on our relationships

and on society to protect us from said harms (Cooper, 2015, p. 1358). There are two kinds of dependencies that Fineman (2010) concludes to be crucial in understanding vulnerability: inevitable and derivative (p. 263-4); inevitable is simply put, that in a lifetime, an individual must depend on another human being—no matter what. One may grow out of inevitable dependency, but, eventually may become vulnerable to factors of life. It is experienced by all, in one way or another (Fineman, 2010, p. 264). Inevitable dependency appears to be deemed as a factor of life, and there is no way to avoid it. The other form of dependency that Fineman (2010) speaks to is derivative dependency; this is explained as a social construction of dependency—for example, being dependent on a parent because we have been subjected to the social construction that individuals are dependents of their parents or their family in a traditional way (p. 264). Derivative dependency seems to be another naturally occurring dependency that could possibly turn into a problem for vulnerable individuals since they may be troubled by becoming a burden to their family or their caregivers. A trend here is that both forms of dependency do not really help to locate vulnerability; instead it seems that vulnerability is being rationalized by the two kinds of dependency. However, it is important to differentiate the two kinds of dependency that Fineman (2010) has marked, since, it is arguable that we would not be able to navigate different aspects of vulnerability, especially since derivative dependency seems to overlap with autonomy. These two points seem to be connected, since derivative dependency appears to be a rational choice—one that has been accepted by individuals to follow through with being a dependent or being depended on; moreover, this is, in a sense a self-governing decision, since the individual that is being depended on is likely in this position because of the socially constructed foundation of traditional roles.

The third element to Fineman's (2010) vulnerability theory is that of complexity. Vulnerability is complex since one can be vulnerable in many different ways, sometimes with an overlap of different factors that may make an individual vulnerable. In addition to this, vulnerability can cause harms in a physical and emotional way—directly and indirectly. Direct vulnerability could impact the self, and indirect vulnerability could be an impact or harm that causes negative effects to those things surrounding one's life, such as personal relationships (Cooper, 2015, p. 1358). Moreover, these harms could impact individuals through institutions, since there are groups and individuals that may be subjected to being harmed because of their vulnerability. This element of vulnerability is most applicable to concerns surrounding debates regarding physician-assisted dying, since it acknowledges that there may not be easy answers or a one size fits all model.

The fourth and final element of vulnerability theory is particularity—meaning that each person may face vulnerability in a different 'particular' way, and that ultimately, vulnerability is 'uniquely experienced' (Fineman, 2010, p. 269). Fineman (2010) argues that particularity is a crucial aspect of vulnerability theory because a person is individually and institutionally positioned, therefore, in both aspects an assessment needs to be made on whether the harms that are forced upon a person because of their vulnerability can be reduced (Fineman, 2010, p. 269). An assessment of how individuals are institutionally positioned could mean recognizing whether they can access the rights and services that they need. If an individual is able to access the resources that they need, it can benefit their well-being; this is important to maintain living a vulnerable life, rather than defeating it entirely (Fineman, 2010, p. 269). This is related to the physician-assisted dying debate, since it is a representation of how important it is to respond to and be aware of the differences in vulnerability and it is possible that limitations should be



thoroughly examined and established to protect those who can maintain their vulnerable life through alternatives to aiding an individual in ending their life.

Particularity is important to the vulnerability theory, especially since it holds together the other three elements: universality, constancy, and complexity; it provides that though vulnerability is universally happening—to everyone in one way or another, and that though it is constant and unsurmountable, complex and multifaceted—it adds finally that vulnerability is still experienced individually, and that it impacts ones' life in a personal way. That is not to say that two people may not be facing the same vulnerability—or living it at the exact same time, but it is arguing that everyone may face it differently—depending on their own dependency, access to resources, and success in autonomy.

These four factors of vulnerability help to direct how to label individuals as vulnerable, and to understand how and when an individual develop into a vulnerable state. Besides the fact that Fineman's (2010) vulnerability theory addresses a lot of key aspects to vulnerability, deeming vulnerability in the simplest of terms to be the result of a natural disaster and a feature of life (Fineman, 2010) takes away from the connections to disability and the fact that vulnerability and disability are seen as inter-related in the literature.

In Fineman's (2010) words, she states that “one of the most troubling aspects of the identity approach to equality is that it narrowly focuses equality claims and takes only a limited view of what should constitute governmental responsibility in regard to social justice issues” (p. 254) Additionally, a concern is that society is structured in a way that focuses more on the majority of the population and not those who are not defined within it (Fineman, 2010, p. 274). Fineman (2010) suggests a need for societal institutions to adapt to fit the needs of those who are

being treated unequally; this is arguably possible if the state redistributes wealth towards structuring institutions and laws to include those who are vulnerable (p. 274). “By adjusting unjust distribution of privilege and opportunity across society would also contribute to a more robust democracy and greater public participation” (Fineman, 2010, p. 274); this ties in with disability studies, since there is an assumption that most are able-bodied persons, so, those who are disabled are overlooked within: “architectural plans, policy initiatives, strategic objectives, organizational structures, systems, budgets, laws, and decisions...[and are simply] not taken into account” (Frazee, 2003, p. 259). This leads to the next section of the literature review, that will examine and relate Fineman’s (2010) Vulnerability Theory to Nussbaum’s capabilities approach and to a further analysis of how these concepts fit together.

### *Nussbaum’s Capabilities Theory*

Martha Nussbaum’s (2006) capabilities approach is based on ten human capabilities—or what they should be; she argues that if these are not reachable in the most basic of terms, that the lack of these capabilities does not amount to “a life worthy of human dignity” (Nussbaum, 2006, p. 78). These ten fundamental capabilities are listed as: life, being able to life a life in a way that is arguably worth living (p. 76); bodily health, having good health (p. 76); bodily integrity, meaning that an individual has the ability to be mobile and protect themselves from physical harm, as well as opportunities to seek out and follow through with human relationships (p. 76); ‘senses, imagination and thought’, being able to use these senses rationally and by one’s own free will (p. 76); Emotions, feeling emotions—good or bad and not being told or taught how to feel (p. 77); Affiliation, part one is being able to have freedoms to live among others and have a social identity, part two is being able to live a life without discrimination, and have self-worth and self-respect (p. 77); Other species—meaning that one can choose to live and appreciate the

world (p. 77); Play, meaning that an individual can partake in fun activities (p. 76); finally, ‘Control over ones environment’, part one meaning that an individual has the right to choose their own identity in a political sense, and part two being material, as an individual being able to have their own belongings or property, to seek out employment and being treated with the same freedom and equality as those around them (p. 77-78).

The ten capabilities that should be present in an individual’s life in order to deem their life worthy of living (Nussbaum, 2006, p. 78), are important to address when examining disability and vulnerability literature, and how they connect. If an individual feels that they are deemed vulnerable or disabled in a way that they cannot correct or be corrected through institutions or other resources within society it would be important because by being responsive enough to allow individuals the right to their own autonomy, and for their own lived experiences to be evaluated by their own idea of where they fall under capabilities—it would create for a much more dignified life, of equal opportunities, and autonomous state. Furthermore, these ten capabilities are often taken for granted by those who are not missing any of them, and this can be seen in how legislation surrounding those who are facing disabilities or suffering from a form of vulnerability is implemented and ‘framed’ (Frazee, 2003, p. 260). Moreover, these individuals that are making judgements and passing laws that impact a vulnerable person’s life, are likely not facing such impairments themselves and this is a very visible component and shortcoming of society’s responsiveness to vulnerable populations.

### ***Further Analysis***

Kaul (2013) argues that disability is connected to the universality of vulnerability, and that disability as a function (p. 94) is difficult to label, since, the capability of an individual's disability is experienced in a personal way, and thus could fall into the possibility of becoming 'de-legitimized' (p. 94), since society is not experiencing this one individual's ability to access rights. However, it is not realistic to assume that all individuals that are facing disabilities are helpless or that they are not living up to what is deemed to be a 'quality-life' (Lid, 2015, 1561); in fact, it is more likely that those individuals who are disabled are more likely to want to be included and have equal opportunities to reach the resources in life that they need—to make their life experience as satisfactory as it can be (Lid, 2015, 1561). Nonetheless, Lid (2015) argues that the capabilities approach interconnected to vulnerability theory and that by connecting the two (p. 1563), we can separate and reframe the approaches that individuals are necessarily 'vulnerable or invulnerable' (p. 1563). This ties in with Butler (2014), since she recognizes the assumption that vulnerability or disability may only be a part of one's life for a short period of time—or at least that is how it is portrayed (p. 115) Lid (2015) critiques Fineman's understanding of the universality component and illustrates that "we need a concept of the human that emphasizes vulnerability as a fundamental human condition. The experience of vulnerability changes, but not vulnerability as a basic condition" (Lid, 2015, p. 1564). To examine this further, Fineman (2010) indicates that assessing vulnerability can be useful in unravelling disability or terminal illnesses and that by doing so, we can move forward in addressing public policy and law (Lid, 2015, p. 1559; Fineman, 2010, p. 269). Furthermore, vulnerability plays a key role in policy inquiries, since some groups demand protections due to their vulnerabilities (Butler, 2014, p.111); Butler (2014) insists that some vulnerable groups are

targeted because of their vulnerabilities and thus it poses an interesting dynamic for laws and legislation, since, ultimately if certain groups that are vulnerable or disabled may be targeted, it is up to government institutions to protect them from harm (p. 111). Although these protections need to be examined further, since equal opportunity to accessible rights and autonomy should still be the main goal for all the population. when in many cases, an individual has likely had to adapt to their disability, or accepted their vulnerability and let go of the incapability to do the things that they were once able to do. It appears that this is what Butler (2014) is trying to reach at, by outlining that there are different ways of being vulnerable, and that the term alone may be too broad on its own.

In addition, the connection that Nussbaum (2006) makes between dignity and vulnerability is that individuals are likely to face dependency and so by creating a discussion around dignity and vulnerability, it provides challenges to rights, citizenship, ethical and political attitudes (Lid, 2015, p. 1558; Nussbaum, 2006, p. 160). Furthermore, the capabilities that Nussbaum (2006) thoroughly explains, can be extremely useful in identifying the overlap between the capabilities approach and Fineman's (2010) vulnerability theory, since both argue that dependency is universal for humanity (Lid, 2015, p. 1557).

Other factors that contribute to the challenges that both vulnerability and disability face are that since society is not yet completely accessible to these groups; a key theme within these perspectives is the illustration that though accessibility is arguably a civil right, it does not mean that there are going to be changes to the way that policy is implemented, or even to the way that society is built upon (Wendell, 1996, p. 66). Furthermore, the notion that helping those who are facing disabilities is simply charity work, makes the process of widespread adaptation to fit all the needs of society a difficult task (Wendell, 1996). A related aspect is the consideration that

“much disability policy and practice assumes that disability must have enormous economic disadvantages, or else large numbers of people will want to be, or to pretend to be, disabled...” (Wendell, 1996, p. 64); this is a significant point that Wendell (1996) addresses, because the misconception that individuals seek out the disadvantaged lifestyle of being disabled is incredulous. A theme emerging from the literature is that it is quite clear that those who are deemed disabled and vulnerable do not wish to be treated differently—they would rather receive equal treatment, but are unable since they must adapt to the social barriers because society has no idea what it really is to be disabled (Frazee, 2003).

Wendell (1989) argues that the existence of a theory of disability is crucial in understanding disability because she argues that it is a social constructed mechanism (Wendell, 1989, in Davis, 2006, p. 243); furthermore, she argues that disability theories would likely be useful to take on a feminist perspective because these perspectives are already familiar with inequality arguments and that there is an abundance of disabled women involved in the feminist movement (in Davis, p. 243), and this argument is illustrated by scholars within this literature review such as Butler and Frazee. In addition, Wendell (1989) states that “disabled people share positions of social oppression that separate us from the able-bodied” (in Davis, 2006, p. 252), so, using a feminist paradigm would help to build disability studies further and contradict the what is considered to be normal (p. 252).

Garland-Thomson (2003) expands on Wendell’s (1989) argument, stating that expansion of feminist perspectives into disability studies will help both paradigms, and that ultimately this is useful for all ‘the sociopolitical world’ (Garland Thomson, 2003, in Davis, 2006, p. 271); moreover, there are a surplus of individuals within society being deemed disabled now, since, they are no longer meeting the criteria of what is ‘normal’ (Wendell, 1989, in Davis, 2006, p.

246). Wendell (1989) refers to disabled persons as the ‘other’ because of the distinct differentiations between them and what is normal. She argues that even if you are one of the ‘other’ your experiences will be “invalidated...[because] other people are the authorities on the reality of the experiences of your body” (Wendell, 1989, in Davis, 2006, p. 252); this is significant because this argument is basically representing the treatment of those who are deemed disabled and illuminating the fact that many of the policies, laws, and societal institutions/government decisions are based on the ‘normal’ person’s perspective, and this is a detriment to disabled society, since their voices are not being heard equally, and, their needs are not being met—so, they are facing discriminatory institutions. This is an interesting perspective that Wendell (1989) brings to the forefront of what disabled persons are referred to, since earlier on in this literature review two definitions were provided for disabled, and impairment. The term for disabled previously stated was used by the United Nations and examined in Wendell’s (1989) paper, so, it is representative of the fact that this concept of ‘normalcy’ has been around for a long time, and it shows that equality for disabled individuals is still not where it should be.

With all of these aspects in mind, it is apparent that there is much discussion on the importance of disability studies and these approaches within them; it is important to realize that the system is failing and it is crucial to accept that there are parts of society facing inequalities, lacking liberties, and so, it is necessary to evaluate these perspectives to make amendments to society, rather than forcing individuals to adapt their own living conditions.

## *Chapter 5*

### *Analysis: Bill C-14(2016) and the Charter*

Assisted-dying policy in Canada is failing those who wish to receive medical assistance. When Bill C-14 (2016) was passed with amendments, there was a chance to make changes to the policy that would have helped make MAID an accessible, feasible option for those that are suffering intolerably. The objective of the prohibition on assisted-dying was to protect the vulnerable (*Carter v. Canada*, 2015, para. 86), and the *Carter* decision explained that that a blanket prohibition did not just protect the vulnerable but “sweeps conduct into its ambit that is unrelated to the law’s objective” (*Carter v. Canada*, 2015, para. 86). This is important to take note of because there are similarities between the blanket prohibition and Bill C-14 (2016). Nowhere in the *Carter* ruling does it state that a ‘reasonably foreseeable’ death is a mandatory requirement for PAD. Unfortunately, the suggested removal of the ‘reasonably foreseeable death’ criterion was ignored and the policy became law. The majority Liberal government refused to back down by allowing amendments to remove the reasonably foreseeable clause (Throap, 2016). Bill C-14 (2016) does not balance the need to protect society and at the same time act as an accessible and equal option for those whom may be requesting it. Bill C-14 (2016) is unconstitutional because it still impacts those that are competent individuals who cannot consent to PAD. This is due to the fact that their deaths may not be reasonably foreseeable even though they still meet the other criteria set out by the policy. There is little difference between a complete ban on assisted-dying and only allowing individuals that are inevitably going to die. This is a loaded term, since every single person will eventually die, but Bill C-14 (2016) requires those requesting MAID to have a looming death.



This analysis will explain that the Bill C-14 (2016) is unconstitutional because it is not in line with the *Carter* decision. Bill C-14 (2016) has several shortcomings and this analysis will unpack these shortcomings by explaining how it is unconstitutional, and the populations specifically that it is failing. Bill C-14 (2016) is in violation of the *Charter* and is not in accordance with the Principles of Fundamental Justice (POFJ) as found in section 7 of the *Charter*. the analysis will also show how the *Bill* is just a revised version of the assisted-dying prohibition in the *Rodriguez* era. The chapter will conclude with recommendations on how to fix this legislation by using disability studies and vulnerability theories. Minister of Justice and Attorney General of Canada Jody Wilson-Raybould (2016) explained that that the policy is meant to strike a balance between accessibility and protecting those that are vulnerable (Justice Committee Meeting, 2016). Wilson-Raybould is arguing this without having a clear understanding of what it means to be vulnerable and how vulnerability may impact autonomy, dignity, or quality of life. Bill C-14 (2016) may appear to be a well-put together Bill because it provides guidelines for MAID to be followed within Canada, but the truth is that the *Bill* does more harm than good to those suffering and seeking end-of-life options. Bill C-14 (2016) has a purpose to protect those who may become vulnerable, but to still provide an accessible and autonomous choice to those who are competent enough to do so, in ending their lives. However its safeguards serve more as a prohibitive protection rather than as safeguards because individuals requesting MAID must meet all of the criteria.

### ***'Reasonably Foreseeable Death'***

A major shortcoming of Bill C-14 (2016) is first and foremost the ambiguity of the eligibility criteria, specifically section 241. 2 (d); that an individual's death must be 'reasonably foreseeable.' The *Carter* decision did not include a reasonably foreseeable criterion, a more

important component used by the SCC was that the individual must be a competent adult (*Carter v. Canada*, 2015, para. 147). This component was important for the *Carter* decision because the plaintiff was a competent adult, therefore, they ruled that PAD would be legalized under such terms. The *Carter* decision ruled that a prohibitive ban was catching individuals that did not fall under a category of ‘vulnerable’ (*Carter v. Canada*, 2015, para. 86); this is important because the SCC concluded that not all individuals seeking MAID are vulnerable, and though they may have some sort of disability they can still be capable of making a competent decision, without coercion (*Carter v. Canada*, 2015, para. 86). I draw attention to this point, because while examining Bill C-14 (2016) one must look at the SCC ruling of *Carter*, and understand that the assisted-dying became legal in Canada because the SCC found that the violations of s. 7 rights of the *Charter* were not in accordance with the principles of fundamental justice because they found that the law was overbroad. Bill C-14 (2016) is overbroad as well; it is a policy with the same purpose to protect the vulnerable—and to prohibit MAID and only allow those who are dying.

Canada argues that it is difficult to conclusively identify the “vulnerable”, and that therefore it cannot be said that the prohibition is overbroad. Indeed, Canada asserts, “every person is *potentially* vulnerable” from a legislative perspective (*Carter v. Canada, Attorney General*, 2015, para. 87)

Although vulnerability is hard to assess from Parliament’s perspective, I would argue that for MAID, it is not up to Parliament to determine vulnerability, it is up to the medical practitioners involved to assess possible vulnerabilities, which they are doing. Furthermore, I would argue that it is up to Parliament to draft legislation that follows a SCC ruling, and that the enactment of Bill C-14 (2016) does not follow or even consider the key elements and arguments of the *Carter* ruling. Overbreadth was a key component of *Carter*, and a prohibitive ban on assisted-dying was found to be overbroad because the law was being imposed on those that were not vulnerable and did not need to be protected (*Carter v. Canada*, 2015, para. 86). In addition to this, overbreadth

is applied in a sense that is not infringing society but to whether a law infringes on an individual that has no connection with the law (*Carter v. Canada*, 2015, para. 85) This principle of overbreadth can be easily applied to Bill C-14 (2016)'s criteria since the law "prohibit[s] more conduct than is necessary to achieve the state objective" (BCCLA, Lamb Notice of Civil Claim, 2016, p. 12). This means that though the law allows medical practitioners to make individual assessments, ultimately, the legislation is preventing them from providing a specific set of people within society, those being anyone suffering from a grievous or irremediable condition that does not have a reasonably foreseeable death or is not yet in a state of irreversible decline (BCCLA, Lamb Notice of Civil Claim, 2016, p. 12). A concern that arises from this violation of rights is that Bill C-14 (2016) does not preserve life if it creates the possibility that an individual may take their own life earlier than they would from a natural death, or a physician-assisted death. If the purpose of the original blanket prohibition on assisted-dying was to protect the vulnerable, and to preserve the sanctity of life, then policy makers should recognize that the implementation of unconstitutional legislation could do the opposite of preserving the sanctity of life. *Bedford* (2012) Judge MacPherson held:

When a court is required to decide whether there is a sufficient connection between crime-creating legislation and an alleged interference with an individual's right to security of the person, the court must examine the effect of that legislation in the world in which it actually operates. This assessment is a practical and pragmatic one. (Canada (*Attorney General*) v. *Bedford*, 2012, para. 370).

Moreover, it was argued in *Carter* by the Trial Judge that the right to life is only to be engaged when the policy, law and legislation may cause or create the possibility of death and so "the right to life is limited to a right to not die" (Court of Appeal, para. 1322, in *Carter*, 2015, para. 61). It is possible that individuals may have taken their own life prematurely, because they could not receive an assisted death, then, their right to life or 'right to not die' are impacted upon,

since the government's blanket prohibition would arguably be the cause of said death or suicide. This argument has become a real possibility because of a recent development in the BCCLA Lamb case that has added a plaintiff by the name of Robyn Moro. Moro is also challenging the reasonably foreseeable clause in Bill C-14 (2016) because she suffers from Parkinson's disease and is suffering intolerably (Bryden, 2017). Moro meets all the other eligibility criteria, but does not have a foreseeable death; she has made note in an interview with the *Globe and Mail* that she will take matters into her own hands and starve herself if the legal proceedings take too much time or fail (Bryden, 2017). Moro added that:

What's the point of waiting until somebody's almost dead before you do anything about it? I think they [Prime Minister Justin Trudeau & Justice Minister Jody Wilson-Raybould] should see the result of what they've done. It's fine to create a law and then walk away from it and not think about it too much...but if they had to see people actually having to do themselves in, maybe it would shake them up a little bit." (Robyn Moro in Bryden, *Globe and Mail*, 2017).

This demonstrates that the law is working backwards, prohibiting those that are suffering intolerably from accessing the right to die without giving them the reassurance that they need to know that they can access this right when need be, instead, forcing them to take matters into their own hands—in a cruel and inhumane way.

In addition, it was evident that though the purpose of the law was to protect those who are deemed vulnerable, the law could be implemented in a way that could allow PAD for those who were not vulnerable, while still protecting those who are (*Carter v. Canada*, 2015, para. 31). The section 7 right to life was impacted by the prohibition because without the access of PAD, it could be possible that some may take their own lives before they actually need to, for fear of not being able to have dignity in dying (*Carter v. Canada*, 2015, para. 57). This arguably does not protect those among vulnerable populations, such as those with disabilities. Frazee (2003)

suggests that it is necessary to overcome social barriers that those living with disabilities face by recognizing that: “Disability is not intrinsic, but rather extrinsic. Disability is situated not in an individual pathology, but in society’s failure to embrace diverse ways of being in the world.” (Frazee, 2003, p. 260). So instead of looking at creating a law that is meant to focus on protecting those whom are vulnerable, that it would be in society’s best interests to implement policies which are inclusive of all diverse living conditions, instead of creating more social barriers. A person is arguably disabled because of the environment they are in, because if there was ease of access for those facing impairments (that may make them vulnerable) it would not be a disability anymore—but rather a condition of living. The concept that disability is extrinsic rather than intrinsic goes against how policy is created currently because Bill C-14 (2016) specifically looks at disability (and vulnerability) as an individual category that requires the state to provide extensive safeguards for and blanket safeguards for all of society. But if policy makers applied this concept that disability is extrinsic, they could look at disability less as a feature of what these individuals live with. This would help because it would create a policy that does not feature the problem with an individual but addressing the bigger problem with the system that society is built upon. Policy should be accessible to all individuals and all individuals should be included in policy—this should be the goal. Rather, make policy accessible to these populations that are living in a disabled state or intolerable state of suffering. Addressing the fact that there is not a balance of accessibility and protection, but a weighted scale making policy even more difficult to navigate or access. The problems with policy and accessibility in Canada cannot be fixed entirely by amending Bill C-14 (2016). But, if Bill C-14 (2016) becomes accessible to those with disabilities that are not living in an irreversible state of decline or with a reasonably foreseeable death, it would be a start to creating policy that is inclusive and also sets an example

that disability is extrinsic because society is not viewing those with disabilities as equal human beings, but as a group that is protected more so than the rest.

### ***What Does Reasonably Foreseeable Death Mean?***

Another issue with Bill C-14 (2016)'s reasonably foreseeable criterion is that it is arguably ambiguous because it may be difficult to predict if a person's death is imminent. In addition to this, there is no standard definition for reasonably foreseeable in this context. Is it a few days, a few weeks, a month, or even a year or two? This could ultimately be left open for the discretion of doctors to determine while assessing patients, but this may start a whole conundrum of other issues, such as accessibility. For example, if some physicians reasonably foresee a death within a few months but others see it as a few years, the patient is subjected to the discretion of the medical practitioner, and may suffer longer and ultimately this may impact their quality of life. The Minister of Justice and Attorney General of Canada Jody Wilson-Raybould explained to the Justice Committee (2016) that:

The bill was deliberately drafted to respond to the circumstances that were the focus of the *Carter* case, where the court only heard evidence about people with late-stage incurable illnesses who were in physical decline and whose natural deaths were approaching. The court said the complete prohibition on assisted dying was a violation of *Charter* rights for persons in these circumstances. In this way, the eligibility criteria in Bill C-14 comply with the *Carter* decision. They focus on the entirety of the person's medical circumstances and not on the specific list of approved conditions or illnesses. (Wilson-Raybould, Justice Committee Meeting, 2016).

This criterion was meant to allow flexibility for physicians making assessments for patients' eligibility, however, the *Carter* ruling did not identify a need for a natural foreseeable death and that "a patient must be on a trajectory towards death" (Wilson-Raybould, Justice Committee Meeting, 2016). *Carter* ruled that adults must be able to consent to ending their life, be competent, and have a grievous, irremediable medical condition, causes suffering and that it

could be a disease, disability or illness (*Carter v. Canada*, 2015, para. 127). Therefore, the *Carter* decision did not require Gloria Taylor to have a reasonably foreseeable death to access MAID, nor did it overturn the prohibition of assisted-dying on the terms that those requesting it must have an imminent death. In addition to this, Gloria Taylor was not necessarily ‘on a trajectory towards death’ at all (*Carter v. Canada*, 2015, para. 11-12).

Although physicians and medical practitioners across Canada are held to the same code of ethics and standards as set out by different organizations such as the Federation of Regulatory Authorities of Canada, The Canadian Medical Association and the Colleges of Physicians and Surgeons, medical practitioners may have differing opinions on what can be arguably ‘reasonably foreseeable.’ However, it is possible that the ambiguity of the ‘reasonably foreseeable’ criterion might allow for medical practitioners to take care of patients on a case by case basis. When an individual’s request for MAID is examined and analyzed under the discretion of the medical practitioners involved. This could create issues because it is possible that two medical practitioners may not agree on whether the patient has an imminent death, as well as that individuals might not even request to access MAID if they do not feel that they meet the criteria. Dr. Ellen Wiebe noted that this process is thought out and applied carefully; assessments are made individually and that ‘reasonably foreseeable’ can be held to a variety of factors such as the life expectancy of the individual and the mitigating factors of the cause of their suffering (E. Wiebe, personal interview, February 7, 2017).

Furthermore, Bill C-14 (2016) specifies that all of an individual’s medical circumstances must be taken into consideration when determining whether they have a reasonably foreseeable death, but some of those who are suffering from grievous and irremediable conditions are not actually dying. For example, Julia Lamb, the plaintiff that the BCCLA is representing is not

dying or terminally-ill. She suffers from a ‘progressive degenerative disease’ that causes her to have medical complications, and unfortunately, she could live in a state of suffering for a long period of time (Notice of Civil Claim, 2016, para. 8-10). She does not have a ‘reasonably foreseeable’ death which prevents her from accessing this right, when she may feel that she can no longer endure her suffering (Notice of Civil Claim, 2016, para. 8-10). She is not on a *trajectory towards death*. This eligibility criterion creates an issue because it is forcing individuals to suffer and because of whatever they suffer from, whether it be a disease, an incurable illness or a disability, if their death is not reasonably foreseeable, they lose their right to autonomy and MAID because of it. This aspect of Bill C-14 (2016) proves to be discriminatory and is unconstitutional under sections 7 and 15(1) of the *Charter* because the *Act* is preventing individuals such as Julia Lamb from accessing or requesting MAID. Although it may appear that the *Bill* is trying to protect those with vulnerabilities from being coerced into an assisted-death, it should not produce a blanket of inaccessibility to those that are willing and able to consent to die when they see fit. The BCCLA in the Notice of Civil Claim for Julia Lamb’s case notes that:

The right to liberty is engaged and infringed by state interference with the right of the individual to a protected sphere of autonomy over decisions of fundamental personal importance. The choice to live or die, and to control the when and how of one’s death, are decisions of profound and fundamental importance...the restrictions imposed under the impugned laws, to the extent that they operate to prohibit access to medical assistance in dying, result in a deprivation of the s. 7 rights of the individuals to life, liberty and security of the person. (BCCLA, Notice of Civil Claim, 2016, p. 12).

The BCCLA also made note in the Notice of Civil Claim that there are many other conditions that individuals may live with that cause irremediable suffering and that many of these conditions impact those whom are living in these states before they reach the state of being reasonably foreseeable or in a “stage of irreversible decline in capability” (BCCLA, Notice of



Civil Claim, 2016, p. 10). It is also important to recognize that the *Carter* decision identified that not every individual that “wishes to commit suicide is vulnerable and ... there may be people with disabilities who have a considered, rational and persistent wish to end their own lives” (*Carter v. Canada*, 2015, para. 86). This is important because it shows that the *Carter* decision did identify with the concept of vulnerability and disability, held that medical practitioners are capable to assess each case individually to ensure that no one is being coerced, or under any duress to request MAID. Therefore, it is rather astonishing that Bill C-14 (2016) was passed without taking these fundamental aspects of the case that legalized assisted-dying into consideration.

Though Bill C-14 (2016) requires an individual’s death to be reasonably foreseeable, it does not require an individual to be suffering from a terminal illness. Meaning a fatal illness that will eventually end the individual’s life naturally. Although one of the criteria in Bill C-14 (2016) also states that an individual must be in ‘irreversible decline’ (241.2. b), it again does not state that an individual must be terminally ill. This is a shortcoming, but not in the sense that terminally ill should be a requirement. This criterion is somewhat contradictory because an individual’s death must be ‘reasonably foreseeable,’ but not necessarily terminal. It is confusing how one can be non-terminally ill and have reasonably foreseeable death that is predictable and likely. This this ‘reasonably foreseeable’ criterion creates more ambiguity and questions than necessary.

### ***Important Issues Still Not Addressed***

To examine Bill C-14 (2016) one should make note of the fact that the issue of the mentally ill, mature minors, and advanced requests were not mentioned at all. The independent

review requirement is located at the end of Act which is meant to address these issues.

Considering the amount of time that the *Act* had to be enacted, and the amount of research, reports, recommendations by different scholars and organizations, as well as models from other countries, it is a major downfall that some of these individuals such as mentally ill or mature minors specifically are disregarded in this law. Advanced consent to assisted-dying is also important because some individuals may feel that their life would not be autonomous if they could not eventually make the choice to die because it's what they believe to be their wish.

We can see that s. 7 is being violated by overbreadth, the SCC has traditionally reacted to the infringement with a suspended declaration of invalidity, to give Parliament enough time to review their law and create a remedy (Hogg, 2012, p. 204). This was the remedy chosen by the SCC in the *Carter* case, since it was important to create policy that would fit the needs of society but still preserve the intended purpose of protecting the vulnerable, and preventing suicide (at least prematurely).

### ***Vulnerability***

As discussed above, how vulnerability is difficult to identify and “every person is *potentially* vulnerable from a legislative perspective” (*Carter v. Canada*, 2015, para. 87). This section will address this issue by applying perspectives that could be useful in amending or implementing policy. Disability studies are a useful approach to help policy and law become accessible to those who are impaired by a disability. By understanding what disability is, it may help to decipher whether or not a policy is preventing an individual with a disability from accessing a right that others within society can access or disallowing an individual from making

an autonomous decision and forcing them to forgo their dignity because of their disability.

*Carter* ruled that:

Other people with disabilities take the opposite view, arguing that a regime which permits control over the manner of one's death respects, rather than threatens, their autonomy and dignity, and that the legalization of physician-assisted suicide will protect them by establishing stronger safeguards and oversight for end-of-life medical care. (*Carter v. Canada*, 2015, para. 10)

This regime that was favourable to some in *Carter* has proven to be a more restrictive and less autonomous than expected by those with disabilities because the law has not become more accessible or helpful in handling end-of-life care; it has basically gone from a prohibitive ban to a restrictive policy. In the Report of the Special Joint Committee, members of Disability Advisory committees were heard and made suggestions to the panel by noting the importance of balancing safeguards for vulnerable individuals but also making a recommendation of accessibility for those who are suffering (Ogilvie and Oliphant, 2016, p. 17). This is representative of the fact that the panel of the Special Joint Committee and the Patient Centred Approach made efforts to hear from those who could provide insight on disability and vulnerability. It was also argued in this report that individuals seeking MAID would all be vulnerable in one way or another; so, these vulnerabilities should be assessed, and rather than preventing access to MAID, proper training for medical practitioners would be a safeguard that may help to protect those with irrevocable vulnerability (Ogilvie & Oliphant, 2016, p. 16). It is a difficult task to assess an individual's state of suffering, because suffering is arguably perceived by individuals in a very different way. It is therefore important for policy to be adaptable on a case by case basis to ensure that everyone's assessment is not generalizable to all individuals requesting MAID.

Most of the recommendations made by the Special Joint Committee were not taken into consideration when implementing the policy. In fact, if one compares the recommendations from the Special Joint Committee to Bill C-14 (2016), very few suggestions were implemented and so the ‘patient centred approach’ was set aside, as were many of the perspectives heard within the report. This is an unfortunate reality of Bill C-14 (2016) is that it does not help to prevent intolerable suffering, it only seeks to protect the vulnerable. We can also see this invalidation of lived experiences of those who are considered/deemed to be vulnerable because policy does not take into account that one does not have to be physically dying to wish to access MAID—many illnesses/ailments/disabilities do not cause death, in fact, some face complications that may cause death, but not in a reasonably foreseeable manner, and this is preventing those individuals from having the reassurance that they will be able to seek out an assisted-death when they no longer feel that they can cope with their experience of suffering. This is significant for MAID policy because some individuals are unable to access end-of-life options such as assisted-dying in facilities that do not offer it. These individuals are being discriminated against and are forced to suffer because they must be transferred out of these institutions to receive access to their right. Individuals are living without the reassurance that they will be able to seek out the help that they might wish to receive and it may put pressure on these individuals, impacting their quality of life, and could cause them to end their lives prematurely, which completely defeats the purpose of the intent of Bill C-14 (2016) in the first place.

Nussbaum’s (2006) capabilities approach is a useful approach to assess the quality of life of an individual, help to inform the working definition of vulnerability since many of the capabilities that those who are vulnerable do not have are characteristics that the majority take for granted. The capabilities approach could be used while implementing policy into Canadian

legislation because the importance of the ten human capabilities approach that she frames is also what could be argued as ‘societal values’ such as bodily integrity and living without discrimination (p. 77). In applying this approach to policy, Nussbaum explains that the goal is to have all members of society to be living a life of quality above and beyond what she terms the ‘capability threshold’ (Nussbaum, 2006, p. 71). Nussbaum notes that society must move away from the average ranking system for the population and move towards a model that illustrates individual quality of life (2006, p. 72). Furthermore, Nussbaum’s capabilities approach supports these rights as the ‘central human capabilities’ because they are necessary for a life worth living, and a life lived with dignity (Nussbaum, 2006, p. 78). Therefore, the autonomy of competent individuals must not be disrespected, and the *Carter* decision displays this. Quality of life and dignity are intertwined with the concept of autonomy. An individual’s quality of life is demoralized when they are not allowed to make their own decisions regarding their life; not only can this be detrimental to one’s beliefs, but also to their health, since, while making medical decisions, quality of life is likely a contributing factor to those who are seeking options, such as MAID. In addition, it goes hand in hand with dignity. Dignity is what those who wish to receive MAID are looking to accomplish—to preserve their own lives until they can no longer live a quality life, and so having autonomy over their body, allows them to exit their lives with dignity, and fulfill their dying wishes. Nussbaum (2006) argues that the capabilities approach is universal, as does Fineman’s (2010) vulnerability (Nussbaum, 2006, p. 78; Fineman, 2010, p. 267). These concepts are both universal because the need to live a dignified life is arguably universal and so vulnerability needs to be universally accepted; individuals experiencing vulnerability still wish to live a dignified life (Fineman, 2010, p. 267). Lid explains that to intertwine the concepts of vulnerability and disability can be tricky because individuals with

disabilities are often regarded as “containers of vulnerability” (Lid, 2015, p. 1563). Universality illustrates the importance for policy makers to approach policy making in a way that is inclusive of the rights of those with a condition such as a disability, and the use of a framework that is inclusive of vulnerabilities too would help to institute a more equal and inclusive society, with the purpose to understand vulnerabilities such as a disability (Lid, 2015, p. 1563). In applying Nussbaum’s (2006) capabilities there is overlap with the *Charter*, individuals should have the right to autonomy, and self-determination; this could be implemented into MAID policy by changing the purpose of the law from protecting the vulnerable to instead protecting all of society. In protecting society, it is arguable that this could mean that all individuals should be protected from having their right to autonomy taken away (as it is being taken away from those in which the law is currently trying to protect). So, to change policy by using a framework that is inclusive of vulnerability (or disability) essentially means to provide equal protection, equal opportunity, equal accessibility, equal rights—not extra protection by means of prohibiting access. Cory Ruf in the interview for this research noted that the BCCLA and Lamb have the support of Dying with Dignity Canada because the law is discriminatory and does not abide by the *Carter* ruling (C. Ruf, personal interview, March 13<sup>th</sup>, 2017). This support may be helpful in raising awareness and identifying the key issues for the future of assisted-dying in Canada. Prohibiting to specific population such as those that are disabled is unconstitutional because their disability does not forgo their right to equal protection or equal benefit of the law. Ultimately, this identification of the necessary application of s. 15(1) will likely be seen in future court proceedings with the BCCLA and Lamb.

### *Charter ‘Dialogue’*

Bill C-14 (2016) is failing Canadians because Parliament did not abide by the *Carter* decision in drafting this legislation. Policy makers ignored the fact that some senators thought the Bill to be unconstitutional because of the reasonably foreseeable criterion. The Bill was passed and some have stated that they hope the courts will fix this issue (Fine & Stone, 2016); however, a remedy might not be quick to make its appearance—the *Carter* case is a prime example of how long it can take to go through the proceedings. Also, legislature had ample time to draft legislation that correlated with the SCC’s decision, yet they did not. So, there’s really no way of knowing that when the law is challenged that policy makers will address the issue in accordance to the ruling. It appears that policy makers have put themselves above the law and above the courts. This is ultimately not a failing of Bill C-14 (2016) but a failure to the system in which Bill C-14 (2016) was created within.

In understanding the implementation of policy, a discussion that plays a key role is the concept of ‘*Charter* dialogue.’ This approach helps to explain the conversation between the courts and legislatures while addressing the implementation of already enacted policies, and those which are being proposed. In addition, this theory has been widely discussed since the enactment of the *Canadian Charter of Rights and Freedoms* in 1982, and so this dialogue has made advancements and evolutions throughout the way—with a dialogue about dialogue. The next section will explore certain aspects of this dialogue and analyze how the courts and legislatures are meant to work together while seeking out ways to implement law that demonstrates the values of the *Charter*. In addition, the next section will argue that though ‘*Charter* dialogue’ is evident from cases that have been brought to the Supreme Court of Canada (SCC), it is possible for dialogue to be ignored, or overruled by legislative bodies.

Hogg, Thornton and Bushell (2007) illuminate the concept of legislation being created after the SCC makes an important decision regarding a *Charter* challenge as “*Charter* dialogue” (p. 4). *Charter* dialogue means that when the Courts come to a decision regarding a *Charter* challenge, parliament usually responds by creating or amending legislation to fit the needs of the ruling while still making note of a law’s original purpose. This dialogue which Hogg et al. (2007) are referring to is crucial in understanding the way that Canadian policy is implemented because it is representative of the fact that the courts do have influence on legislatures. However, Hogg et al. (2007) make note that even if the courts decide that a law or piece of legislation infringes on the *Charter*, does not mean that Parliament will necessarily change a law and “in most instances, the judicial decision did not preclude legislation that continued to pursue the objectives of the original law” (Hogg et al. 2007 p. 4).

Decisions made by the courts regarding policy and law may not be of interest to the political party in power, so changes made by Parliament may not become a priority if they do not fit the direction that the political party in power is guided by. Hogg et al. (2007) explain that even if the courts rule on a law, it does not necessarily mean that the law will be changed or addressed at all (p. 46). Hogg et al. (2007) argue that this is due to the ‘concentration of power’ (p. 43) in Canada, and that those in power generally have the last say in what happens to legislation since some decisions made by the courts may not fit the needs or the plan that the political party in power has (p. 43). Peter Julian of the NDP in British Columbia noted that:

The Liberals chose to play politics with this matter of rights [the right to medical assistance in dying, as per *Carter*]. The Liberals refused to listen to the experts and rejected all of the opposition’s substantive amendments... two courts, the Alberta Court of Appeal and the Ontario Superior Court, say that what the Minister of Justice just said is wrong, and we trust those court decisions.  
The Liberals have badly mishandled medically assisted dying. It should have been non-partisan and evidence-based, and they have made it political. They steamrolled Parliament to pass an unconstitutional bill. Now the Senate is refusing to pass the



legislation without the amendments we proposed. Liberals know full well that their bill will not survive a court challenge. Will they now admit that the bill must be fixed, and will they fix it? (Peter Julian, NDP, House of Commons, Hansard #69 of the 42<sup>nd</sup> Parliament 1<sup>st</sup> Session. June 9<sup>th</sup>, 2016).

Julian's comments in the House of Commons represent a deep underlying issue with Canadian politics. Primarily that there was ignorance towards MPs while implementing legislation and that the constitutionality of the Bill was brought into question and ignored. This is an example of *Charter* 'dialogue' being brought up and ignored. This bill will likely need to be reformed but the issues were identified whilst it was still being drafted, so a constitutional challenge likely could have been avoided.

Hogg et al. (2007) make note that "*Charter* decisions rarely defeat a major legislative policy" (p. 40). If this is true, then the courts must continue the discussion between legislatures and judicial review, by hearing the issues that infringe upon the *Charter*. This may create an immediate response from policy makers, but perhaps it may create a disturbance in the way the political party in power is perceived by the public; this disturbance could be a public outcry by means of a protest, or a loss of power in the next election. This is important since Hogg et al. state that ultimately in this democracy, society usually agrees with judicial decisions related to the *Charter* (2007, p. 42). If society generally agrees with judicial decisions, then it is possible to insinuate that the courts do hold some power towards change in legislation. Hogg et al. argue that it is up to the Court to interpret the *Charter*, and this helps to protect the rights of society (2007, p. 42). Hiebert (2002) argues that the dialogue between the Court and Parliament is a joint effort in interpreting the *Charter* (p. 4); and that the *Charter* is meant to be used to inform the creation of policy (p. 4). Hiebert states that:

The Constitutional status of the *Charter* increases the relevance of political evaluation of bills because new consequences arise from inconsistencies between legislation and protected rights. Courts are empowered not only to review legislation but also to grant

remedies for breaches, which may include the nullification of legislation in whole or in part (Hiebert, 2002, p. 7).

Historically, Roach (2007) explains that there has been a dialogue between the SCC and Parliament, since the Courts have helped to interpret and explain policy since the beginning of the common law (p. 456). Therefore, dialogue is merely a feature that has been expanded on since the implementation of the *Charter* in 1982. Hiebert (2002) explains that the dynamics between the Court and Parliament suggest that there have been adaptations made to the implementation of bills regarding important rights. If the government fails to abide by a judicial review, or implements legislation that fails to work with the *Charter* rights, there are consequences for these bodies of power and these consequences have made other public departments more favourable, such as the Department of Justice (Hiebert, 2002, pp. 7-8). This means that the public may favour the Court system more so than policy makers because they may feel that they are protecting their rights.

However, there has been much movement towards reviewing future legislation by addressing the *Charter* in the initial stages of creating new bills, in hopes to avoid future challenges and to create legislation that is reasonably applicable to Canadian society (Hiebert, 2002, p. 7). This is done by a ‘risk assessment’ to see whether a policy may create a *Charter* issue (Hiebert, 2002, p. 8). This task is undertaken by Department of Justice lawyers and are labelled on a scale from what risk they create (p. 8).

It is significant to realize that during the implementation of legislation, a consistent *Charter* dialogue can help to prevent the violation of rights—this dialogue has been suggested by justice departments to remedy issues that may arise specifically to the *Charter*, before they occur (Hiebert, 2002, p. 10). *Charter* assessments and policy can arguably only strengthen a bill in the

long run; this is because the government can show that they are recognizing that a somewhat sensitive area may need to be reviewed by external bodies so that eventually when the legislation is implemented, it does fit the needs of society and fit the original purpose that it was meant to fulfil (Hiebert, 2002, p. 10).

Hiebert (2002) places value on a continuous dialogue between the Court and Parliament but not only after the Court provides a ruling. The ruling is important so that Parliament is aware of what aspects need to be reviewed, and though this isn't a real conversation per se, it is still a dialogue (p. 50). In addition to this, Sterling (2007) argues that the goal of implementing policy is that a negative ruling never comes from a piece of legislation—and so there to be no discussion after the fact, rather, that a policy is assessed thoroughly before it receives Royal Assent; it is important to realize that most of the implemented legislation does not infringe upon *Charter* rights (Sterling, 2007, p. 141).

Sterling (2007) notes the two elements that support that the government recognizes the importance of *Charter* values. First, that the government wishes to not have legal issues arise from an implemented policy, and second, by creating policies that do not create *Charter* challenges, it supports the values of the *Charter* (Sterling, 2007, pp. 147-148). I agree with this, partially because in theory the government believes in the *Charter*, and believes that individuals should believe that they have their rights—but if an individuals' rights being imposed upon are interfering with a political motive/value that does not correspond with the political power's beliefs/values, then it is possible that these rights may be overlooked. Public values are hard to determine, since Canada is divided by provinces/territories, different religions, differing political values. I think it is likely that to take into account the public values means to take into account the political power that is the majority and put forth their values; assuming that their values are

the most favoured by society since they hold the majority. However, it is possible to argue that since the *Charter* values have been interpreted differently over many years, that the public values have as well, and so they may be arguably linked (Carter, 2015).

The concept of governing while using the *Charter* is using the dialogue between Parliament and the Court to connect the rights of the *Charter* with the anticipated policies and their purposes (Kelly, 2005, p. 223). Kelly makes note of the fact that though ultimately advice by the Court or by assessments made by other bodies such as lawyers or the Department of Justice, the advice can be ignored (Kelly, 2005, p. 224). This is representative of the implementation of Bill C-14 (2016) when there were senators stating that they felt the policy was unconstitutional (Fine & Stone, 2016). What's more, is that there were MPs and Committee's created while drafting this policy and yet their recommendations vastly were ignored. Peter Hogg addressed Bill C-14 (2016) specifically and advised that the Bill would be challenged (*Dying with Dignity*, 2016). The *Carter* decision advised that: "It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons" (*Carter v. Canada*, 2015, para. 126), but, it is clear now that Bill C-14 (2016) has been implemented that the legislation is not consistent with the decision made by the SCC. Kelly (2005) strongly suggests that the invalidation of policy is an indication of what goals retain to the political party in power, and ultimately are representative of those bodies (p. 224). Additionally, decisions regarding the reaction to a declaration of invalidity are arguably political in their nature—meaning that the policy implemented is meant to suit the position and agenda of those in power (Kelly, 2005, p. 224).

Bill C-14 (2016) is an unconstitutional piece of legislation implemented by policy makers that did not care to listen to advising councils, committees or court rulings while drafting a

policy that was meant to fit the needs of society. Bill C-14 (2016) is representative of the failing system of government and policy and this failing system will continue to produce poor policies unless real change and motivation to change occurs. Sadly, specific to assisted-dying legislation in Canada, it may take a lot of time to challenge the law, and these lengthy proceedings will cause more harm and suffering, as well as possibly forcing individuals to take their lives prematurely all because of a safeguard that fails to provide safety. Autonomy, dignity and liberty were all key components in the *Carter* decision but as it stands for the law implemented by the government, there are members of society that are apparently not entitled to live an autonomous, dignified and liberty filled life.

## Chapter 6

### *Conclusions: What's Next for Policy*

Canadian policy has taken a step forward by implementing Bill C-14 (2016) and legalizing assisted-dying; some Canadians are now able to access this end-of-life right and end their intolerable suffering. Unfortunately, Bill C-14 (2016) it has proven to be inaccessible, restrictive, and ambiguous in many ways, as were discussed. It is important that policy makers recognize that when a law that they support is found to be unconstitutional that it is necessary to remedy the issue that makes a law unconstitutional. I would argue that we are not there yet; the *Carter v. Canada* (2015) ruling exemplifies this by striking down the prohibitive ban of assisted-dying, all the while the legislative response was to implement a policy that remains to be just as restrictive and unconstitutional. Hogg (2007) explained that even when legislation is found to be unconstitutional, it does not mean that a law will be created that does not serve the law's original purpose (p. 4). It is likely that until Bill C-14 (2016) is found unconstitutional through a lengthy court ruling (such as the one brought by Julia Lamb), the rights of those wishing to access MAID and make the autonomous decision to do so, will have to wait. They will be among many others waiting to hear the verdict of their lives. In 1992, Sue Rodriguez asked "If I cannot give consent to my own death, whose body is this? Who owns my life?" (CBC News, 1992). The answer unfortunately is not a given, and though it is certain that Rodriguez would meet the criteria of Bill C-14 (2016) today, her question remains true to many Canadians whom are living a life without the sureness of their dignity or autonomy, without quality of life, and without the fundamental freedoms of life, liberty and security of the person.

It is possible to resolve the shortcomings of Bill C-14 (2016) in the next couple of years, but also to use the independent reviews to approach possible changes to policy in a way that supports

those that are may wish to access MAID. Minimally, policy should be accessible to those individuals that meet all of the eligibility criteria. What's more, is policy should be not be discriminatory or implemented when it is likely that it was deemed or argued to be unconstitutional before it was even enacted. There is little information on how the independent reviews will be conducted or whether they will be using models from other parts of the world to help answer difficult questions such as MAID and mature minors, mentally ill and advanced consent. The independent reviews produced may provide a wealth of knowledge and insight to navigate these difficult issues within MAID policy, but the Canadian government has already proven to be narrow-minded while considering policy changes. This is illustrated by the process of the enactment of Bill C-14 (2016) and how few of the patient-centred policy recommendations that were made were put into policy. If these reports and committees were put together prior to the drafting of Bill C-14 (2016), to provide feedback and recommendations to Parliament, it is not distinctly clear why a policy that is not in accordance to the *Carter v. Canada* (2015) ruling implemented. Bill C-14 (2016) does not use a patient-centred approach, or even a vulnerabilities approach—yet, the *Act's* preamble recognizes the importance to protect vulnerable populations (Bill C-14, 2016). This is hypocritical because it is clear that Parliament does not know how determine vulnerability, how protect those who may be vulnerable, whom experiences it, how it can be experienced, and lastly, what/who created the concept of vulnerability.

Some priorities that need to be addressed by Parliament are that first and foremost, MAID needs to be accessible throughout the provinces, especially in publicly funded institutions. Institutions that refuse to provide services that a patient may wish to receive should be held accountable by helping them reach those services in a timely manner. Institutions should not be able to refuse MAID if they have a willing physician to aid the patient in need. Forcing

individuals to transfer to another institution or leave the premises is inhumane, especially when they are in need of a supportive health care system in their final days. It is necessary for policy to come up with a consistent way to determine capacity—one that does not use age as a limit. Age may not be a consistent use of determining one's ability to give consent because across Canada, the age of majority differs in each province, and, those who have reached age of consent but are still considered to be minors are able to make other life-changing decisions about their lives. Mature minors should go through the same assessment criterion that any other individual would go through to receive an assisted-death.

The most important aspect of policy that needs to be addressed is the 'reasonably foreseeable' criterion. The ambiguity it applies does not support patients in need, it provides uncertainty and may impact whether physicians wish to provide MAID if they are tentative of the standards because of this ambiguous criterion. Limiting access to MAID by declaring that all individuals must have an imminent demise will prove to continue forcing members of society that are suffering to continue to live in this state of intolerable suffering, and unfortunately, they may be forced to take their own life prematurely, travel abroad or receive MAID in an unlawful way.

The enactment of Bill C-14 (2016), Ontario has drafted legislation called Bill 84: *An Act to amend various Acts with respect to medical assistance in dying*. This piece of legislation is currently being considered by the Standing Committee on Finance and Economic Affairs. Dying with Dignity Canada (2017) has made statements regarding the proposed piece of legislation explaining what amendments members of parliament are seeking to make. Some positives that Bill 84 would provide with for those in Ontario would be that it would make it less worrisome for medical practitioners to be involved in MAID, by ensuring that they will not be brought into



lawsuits so long as they follow the standards and guidelines put forth in Bill C-14 (2016) (Dying with Dignity, 2017). In addition, it would help to provide clarity for declarations on insurance policies and ensure that family members of those individuals receiving MAID will still be able to make claims even if they receive MAID, by making this law (Dying with Dignity, 2017). However, these two aspects of Bill 84 may be positive, there are several issues that arise with this proposed legislation. The issues that are apparent within these amendments illustrate the fact that Parliament is still not using a patient centered-approach to create policy. First and foremost, by protecting public institutions from reporting their policies or producing these records when asked for in respect to assisted dying. According to Dying with Dignity Canada (2017), this is problematic because it makes it difficult for individuals accessing these facilities to know what rights they can access while using them, such as MAID, and this impacts the accessibility and clarity of the patients (Dying with Dignity Canada, 2017). Secondly, by making it law, in accordance with Bill C-14's (2016) criteria that all MAIDs must still be reported to a local coroner. This is detrimental to the families involved because if a coroner sees fit, they may initiate an investigation of a MAID if it is not up to standards; this is a sensitive matter for families, and not one that needs to create more fear, or uncertainty (Dying with Dignity Canada, 2017). This may also deter an individual from accessing their right to MAID if they believe that it could cause harm to their loved ones in which they would be leaving behind, thus forcing them to suffer more so than necessary. Finally, calling MAID a suicide—this term is damaging to the family members involved, but it is also detrimental to data collected by the government. If MAID is being reported as a suicide, it may impact the real statistics and impact future amendments to MAID policy (Dying with Dignity Canada, 2017). Another issue with labelling MAID a suicide is that policy has moved away from the term 'assisted suicide' and as

recommended by the Special Joint Committee toward the use of the term medical assistance in dying (MAID) (Ogilvie & Oliphant, 2016), thus creating another policy that does not use the same term is inconsistent and misleading. In other words, Bill 84 is just an example of how the assisted-dying debate is ongoing; there are clearly many aspects of MAID policy being reviewed.

It is also important to discuss how Bill 84 will impact Canadian society, far and wide. If Bill 84 receives Royal Assent, it will be interesting to see whether other provinces follow suit with a similar provincial piece of legislation. Also important is the point that if Ontario's Bill 84 is passed, what will happen to Ontarians? Will they be forced to access MAID outside of their province, away from their homes, and their families because of the inability to access or know which facilities/practices offer this end-of-life right? Even more considerable is the fact that classifying assisted-deaths as a suicide may prevent individuals with religious beliefs/morals from accessing MAID because it would be a sinful act to do so. Furthermore, identifying MAID by reporting it as a suicide is inconsistent with policy that defines it as a medically assisted death. These are all questions which need to be addressed, because if the purpose of the law is to protect individual's rights and those that are vulnerable, then isn't it necessary to examine issues with the approach of those whom will be impacted by the enactment?

Bill C-14 (2016) was passed and enacted with haste. Had the Senate continued to fight with the support from others (some of those quoted in this research), they may have been met with a standstill in the advancement of the policy or removal of the reasonably foreseeable clause. This is represented by the fact that the Senate originally voted against this requirement. But, coming to a standstill (*for weeks, months or even years*) would have been damaging to many Canadians wishing to access MAID and so it could have been in their best interest to pass the *Act*. However, in passing Bill C-14 (2016), it has proven to exemplify the disdain for the rights of those that do

not meet the criterion. The autonomy and fundamental rights of these individuals that are unable to access MAID have been set aside and have basically been prohibited from requesting end-of-life help. It is arguable that the ambiguity of this policy was motivated by those that do not wish to really make a change to the law, and that do not want to be held accountable for individual's taking their own life. In addition, John Wallace, an independent Senator noted concern for the "normalization of suicide" (Tunney, *CBC News*, 2016) This could be related to why the reasonably foreseeable clause was stringently kept in the policy. It is interesting that some policy makers have argued that the *Bill* does not abide by *Carter*, while others defend that it does, while still, there are few others that state that there is no need to follow the *Carter* ruling because of the bigger picture (Tunney, *CBC News*, 2016); this lack of agreement or consistency in understanding the SCC ruling illuminates how messy the process of drafting legislation is, and definitively displays the failing system of policy making in Canada.

It is my hope that this thesis creates a discussion towards the shortcomings of Bill C-14 (2016), but also to illustrate a bigger issue with the creation of Canadian policy and importance of the *Charter of Rights and Freedoms*. The shortcomings of Bill C-14 (2016) are a priority and they need to be examined by using the proper methods to ensure that proposed amendments are capturing the needs of Canadian society. However, the future of medically assisted dying in Canada does not end with Bill C-14 (2016). In fact, if the approach used by policy makers is addressed substantially, it is possible that the future of other policies in Canada will be met with perspectives that fit the needs of the policy and those impacted by it. The dialogue between the Court and Parliament is necessary, but it is also necessary for the public and scholars to continue to help identify issues arising from policy.

This research was not exhaustive, many perspectives and ideas had to be left out to provide with a concise and focused thesis. However, this research identified many other issues that could help to formulate future research questions within the policy and assisted-dying debate. In conclusion, a policy review and two semi-structured interviews served this project well, by helping to add to the MAID discourse throughout Canada. Assisted-dying is being practiced across the globe, with many research surrounding nearly every aspect of the MAID debate; therefore, I have no doubt that assisted-dying will eventually be implemented successfully throughout Canada. However long this takes, may be the real issue to be considered now, not “if” assisted-dying will ever become successfully implemented, but rather when.

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## ***Appendix A***

### ***Bill C-14 An Act to Amend the Criminal Code and other Related Acts (Medical Assistance in Dying, MAID)***

**Definitions 241. 1** The following definitions apply in this

section and in sections 241. 2 to 241. 4. ***medical assistance in dying*** means

(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*)

#### **Eligibility for medical assistance in dying**

**241. 2 (1)** A person may receive medical assistance in dying only if they meet all of the following criteria:

(a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;

(b) they are at least 18 years of age and capable of making decisions with respect to their health;

(c) they have a grievous and irremediable medical condition;

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give 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.

#### **Grievous and irremediable medical condition**

**(2)** A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

### **Safeguards**

(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

(i) made in writing and signed and dated by the person or by another person under subsection (4), and

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

(i) 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.

### **Independent Review**

**Mature minors, advance requests and mental illness**

**9. 1 (1) The Minister of Justice and the Minister of Health must, no later than 180 days after the day on which this Act receives royal assent, initiate 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.**

**(2) The Minister of Justice and the Minister of Health must, no later than two years after the day on which a review is initiated, cause one or more reports on the review, including any findings or recommendations resulting from it, to be laid before each House of Parliament.**

*Appendix B**Bill C-14 Amendments Made by Senate June 15<sup>th</sup> 2016*

WEDNESDAY, June 15, 2016

AMENDMENTS made by the Senate to Bill C-14, passed by the House of Commons, intituled: "An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)".

1. *Preamble, page 2*: Replace line 21 with the following:

"unique needs, and it commits to working with provinces,".

2. *Clause 3, pages 4 to 7 and 9*:

(a) On page 4, replace line 24 with the following:

"ance in dying in accordance with section 241.2, except if they know or believe that they are a beneficiary under the will of that other person, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death.";

(b) on page 5,

(i) add after line 6 the following:

**"irremediable"**, in respect of a medical condition, means not remediable by any treatment that is acceptable to the person who has the medical condition. (*irréremédiable*), and

(ii) replace line 36 with the following:

"condition — including an illness, disease or disability — that causes enduring suffering that is intolerable to them in the circumstances of their condition;"

(c) on page 6,

(i) replace line 5 with the following:

"sistance in dying after having had a palliative care consultation and having been informed of treatment, technology or support options available to relieve their suffering.".

- 2 -

(ii) delete lines 6 to 21, and

(iii) replace line 35 with the following:

“condition, and after the condition has begun to cause enduring suffering that is intolerable to the person;”;

(d) on page 7, replace lines 33 and 34 with the following:

“who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does 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 —”;  
and

(e) on page 9, replace line 2 with the following:

“graphs 241.2(3)(b) to (i) and subsection 241.2(8) is guilty”.

3. *Clause 4, page 10:*

(a) Replace lines 2 and 3 with the following:

“ulations.”;

(b) replace lines 9 to 11 with the following:

“the recipient designated in those regulations.

**(3)** The Minister of Health must make regulations”;

(c) replace line 32 with the following:

**“(3.1)** The Minister of Health, after consultation with repre-”; and

(d) replace line 34 with the following:

“health, must establish guidelines on the information to be”.

4. *Clause 9.1, page 13:*

- 3 -

(a) Replace line 21 with the following:

**“9.1 (1) The Minister of Justice and the Minister of”;** and

(b) add after line 28 the following:

**“(2) The Minister of Justice and the Minister of Health must, no later than two years after the day on which a review is initiated, cause one or more reports on the review, including any findings or recommendations resulting from it, to be laid before each House of Parliament.”.**

5. *Clause 11, page 14:* Replace lines 12 and 13 with the following:

**“11 Sections 4 and 5 come into force 12 months after the day on which this Act receives royal assent or on any earlier day that may be fixed by order of the Governor in Council.”.**

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Clerk of the Senate



*Appendix C*

*Canadian Charter of Rights and Freedoms (1982)*

Legal Rights

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Equality Rights

15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

***Appendix D Excerpt from the Criminal Code of Canada***

*Criminal Code of Canada (R. S. C., 1985, c. C-46)*

**Counselling or aiding suicide**

**241 (1)** Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years who, whether suicide ensues or not,

- (a) counsels a person to die by suicide or abets a person in dying by suicide; or
- (b) aids a person to die by suicide.

**Exemption for medical assistance in dying**

**(2)** No medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if they provide a person with medical assistance in dying in accordance with section 241.2.

**Exemption for person aiding practitioner**

**(3)** No person is a party to an offence under paragraph (1)(b) if they do anything for the purpose of aiding a medical practitioner or nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.

**Exemption for pharmacist**

**(4)** No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

**Exemption for person aiding patient**

**(5)** No person commits an offence under paragraph (1)(b) if they do anything, at another person's explicit request, for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying in accordance with section 241.2.

**Clarification**

**(5.1)** For greater certainty, 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.

**Reasonable but mistaken belief**

(6) For greater certainty, the exemption set out in any of subsections (2) to (5) applies even if the person invoking the exemption has a reasonable but mistaken belief about any fact that is an element of the exemption.

### **Definitions**

(7) In this section, *medical assistance in dying*, *medical practitioner*, *nurse practitioner* and *pharmacist* have the same meanings as in section 241.1.

R.S., 1985, c. C-46, s. 241;

R.S., 1985, c. 27 (1st Supp.), s. 7;

2016, c. 3, s. 3.

### **Consent to death**

**14** No person is entitled to consent to have death inflicted on them, and such consent does not affect the criminal responsibility of any person who inflicts death on the person who gave consent.

R.S., 1985, c. C-46, s. 14;

2016, c. 3, s. 1.

*Appendix E**Carter v. Canada (Attorney General) 2015 SCC 5*

## XIII. Conclusion

[147] The appeal is allowed. We would issue the following declaration, which is suspended for 12 months:

Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.