COLUMN/CHRONIQUE

Medically Assisted Death in Canada—Unsettled (and Unsettling?) Law

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Canada joined an exclusive group of jurisdictions that allow medical assistance in dying (MAD) upon the passage of *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* [1]. The *Medical Assistance in Dying Act* amends the *Criminal Code* by introducing a MAD exception to its culpable homicide and counselling or aiding suicide provisions. The statute was enacted in response to the Supreme Court of Canada's decision of *Carter v Canada* [2] in which the Court found these *Criminal Code provisions* to be unconstitutional as unreasonably restricting an individual's right to life, liberty, and security of the person.

This paper explores several controversial and unresolved provisions of the new statute that health librarians may have to assist their patrons in researching. The former provisions are requiring that the patient's death be reasonably foreseeable, differentiating between the recorded cause and manner of death, and allowing someone other than the patient to sign the MAD request form. The identified unresolved terms relate to the law's application to mature minors and to psychological disorders, and allowing assisted-dying provisions in personal directives.

Reasonable foreseeability

Adults suffering with a grievous and irremediable medical condition may request medical assistance in dying. To establish that a person has a grievous and irremediable medical condition, the medical personnel must determine, among other things, that "their natural death has become reasonably foreseeable … without a prognosis necessarily having been made as to the specific length of time that they have remaining" [3 at s. 241.2(2)].

Constitutional law experts believe the reasonable foreseeability requirement will likely be found unconstitutional as it "is not consistent with the constitutional parameters set out in the *Carter* reasons" [4], a supposition bolstered by the Alberta Court of Appeal's interpretation of *Carter* in *Canada (Attorney General) v EF* earlier this year. The Alberta Court said "[n]owhere in the descriptive language [in *Carter*] is the right to physician assisted death expressly limited only to those who are terminally ill or near the end of life" [5 at para 33]. The reasonable foreseeability of death requirement would have the effect of reducing the number of eligible patients, contrary to the underlying rationale in *Carter*. A constitutional challenge to this provision was filed within two months of the Act becoming law [6].

Canada is not alone in requiring death to be foreseeable. The American model, based on the Oregon statute, contains an imminent death provision requiring a prognosis that the patient's illness will "produce death within six months" [7]. The Canadian reasonable foreseeability requirement is obviously less prescriptive than the American test, but it is also open to subjective interpretation. The Minister of Justice said the "language was deliberately chosen to ensure that people who are on a trajectory toward death in a wide range of circumstances can choose a peaceful death instead of having to endure a long or painful one" [8]. According to the Department of Justice, reasonably foreseeable means "there is a real possibility of the patient's death within a period of time that is not too remote…. While medical professionals do not need to be able to clearly predict exactly how or when a person will die, the person's death would need to be foreseeable in the not too distant future" [9]. As with any ambiguous phraseology in statutes, it will likely be left to the courts to determine the outer limits of the patient's lifespan where their death could be determined reasonably foreseeable.

Cause and manner of death

The Act also requires the Minister of Health to establish guidelines regarding the information that is to be included on death certificates, including whether the cause and manner of death should be identified as MAD or the underlying illness [1 at s.3.1]. The Minister will need to consider provincial laws when devising the guidelines as provincial law requires either a coroner or medical examiner to determine the cause and manner of death for all unnatural deaths. Cause of death relates to why an individual died and manner of death to how the person died.

A hint regarding what the Minister will likely decide regarding the cause of death can be found in the Act.

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The Act amends three statutes other than the *Criminal Code* by adding a cause of death deeming provision. Any persons governed by these statutes (such as inmates and members of the armed forces) who receive MAD will be "deemed to have died as a result of the [underlying] illness, disease or disability" [10]. This suggests that the guidelines will likely stipulate the underlying illness to be identified as the cause of death on the death certificate.

The manner of death could, and arguably should, be recorded as MAD as that accurately reflects how the individual died. Differentiating between cause and manner of death in this manner will allow for more accurate records of medically assisted deaths as well as the underlying medical reasons for these deaths.

Inability to sign

Unique to Canadian legislation is a provision that states if the person requesting MAD is unable to sign the request form, another adult may sign on the patient's behalf if the adult signer understands the nature of the request [3 at s. 241.2(4)]. The signing of the form must be done in the presence of the patient and an independent witness. This provision may raise concerns about vulnerable persons being taken advantage of for financial or other reasons; however, the provision must be read in conjunction with the safeguard section. Among others, the safeguards require medical personnel to ensure the patient gives express consent for the assistance and to take all "necessary measures" to ensure a person who has difficulty communicating understands the information provided to them and can communicate their decision [3 at s. 241.2(3)]. The onus is on medical personnel to ensure that the patient is requesting MAD voluntarily and without undue influence. Presumably, medical personnel whose patient did not personally sign the request would take more care than usual to ensure that the patient truly wishes MAD to be provided.

Unresolved matters

The Act requires the government to initiate an independent review to determine whether MAD should be available to mature minors, to persons utilizing a personal directive, or to individuals solely suffering from a mental illness. This review must begin within 180 days after the Act became law on 17 June 2016 and must be completed within two years [1 at s. 9.1].

Applicability to minors

Currently, the Act only applies to persons at least 18 years of age. This provision will need to be reconciled with the established mature minor doctrine. This doctrine allows minor children who have the intellectual capacity and maturity to understand information relating to their medical condition and to appreciate the consequences of accepting or refusing medical treatment to make decisions regarding their medical treatment. Some provinces have enacted statutes guaranteeing minors with this right, whereas courts in other provinces have granted mature minors this same legal right.

It is impossible to predict what the independent review committee will recommend regarding mature minors. Three previous advisory groups each recommended different actions: not allowing minors to be MAD eligible [11], favouring the law applying to all competent persons regardless of age [12], and offering a two-stage implementation with MAD being extended to competent minors within three years after adults receiving that right [13]. Each advisory group reached their recommendations after consulting with interested parties and considering the experiences in other countries, all of which the future review team will also likely consider.

It is probable, however, that a lawsuit will be commenced at some point if the government fails to extend the Act's application to mature minors. While it is true that the Supreme Court limited its discussion of MAD to adults in the *Carter* case, it did so deliberately. The Court made clear that it was limiting its discussion to the specific facts of the *Carter* case (i.e., adult parties) and refused to make any "pronouncement on the other situations where physician-assisted dying may be sought," suggesting that there may be other situations where it would be appropriate [5 at para 127]. Constitutional law expert Peter Hogg has, in fact, predicted that "[t]he Court would have no reason to object to the widening of the entitled class perhaps to include mature minors, who could thereby acquire a statutory, but not a constitutional, right to physician-assisted dying" [4].

Advanced requests

Provincial governments began enacting advanced personal directive legislation in the 1990s. Personal directives allow individuals to provide instructions regarding future medical treatments when they are no longer mentally competent to make those decisions. Currently, these laws do not allow personal directives to include assisted suicide or any other unlawful instructions. As MAD is now legal, personal directives should, in theory, be allowed to include provisions relating to MAD, but this is not without problems. One difficulty would be melding the personal directive and MAD safeguards in a workable manner. For example, assuming the personal directive replaces the written MAD request form, will medical personnel be required to confirm at the signing of the personal directive that the individual's request was voluntary and without undue influence?

Psychological disorders

While the Act refers to a serious and incurable illness, disease, or disability that causes the patient "enduring physical or psychological suffering that is intolerable to them," the word psychological refers to the suffering the patient is experiencing, not to the illness itself. The Act does not allow individuals solely suffering from a serious and incurable mental disorder to seek medical assisted death. The Justice Minister explained that extending the law to psychological illnesses was beyond the *Carter* decision and required deeper consideration to ensure that the right protections are in place for "the most vulnerable and stigmatized persons in our society" [14]. In fact, the application of MAD to patients suffering with psychological disorders has already been adjudicated by a Canadian court. In May 2016, the Alberta Court of Appeal in

Canada v EF concluded that the *Carter* decision did not preclude patients with psychological illnesses from seeing medically assisted death. The Court concluded the "issue of whether psychiatric conditions should be excluded from the declaration of invalidity was squarely before the [SCC in *Carter*] . . . [but] the court declined to make such an express exclusion" [5 at para 59]. The Alberta Court confirmed that the plaintiff who suffered from a psychological movement disorder was entitled to receive MAD. That decision was rendered before the legislation was passed, however, so the Court did not have to consider how the reasonable foreseeability of death requirement would impact the law's applicability to psychological illnesses.

The passage of the *Medical Assistance in Dying Act* occurred on the Supreme Court of Canada's timeframe and after a change in government, arguably resulting in a less considered and debated statute than a controversial subject such as MAD would normally warrant. Legislation is not set in stone, however, and changes to the MAD laws in the next few years are highly likely, either as a result of further governmental review or through court actions. In time, the law will become more defined and settled and, one hopes, less unsettling to the majority of Canadian citizens.

While this article focuses on the federal government's new statute, Canadian health librarians should remember that provincial governments are constitutionally responsible for the administration of health care in their jurisdictions. Provincial governments and national and regional medical professional associations have significant roles in developing MAD laws, policies, procedures, professional guidelines, code of ethics provisions, and advisory opinions, potentially resulting in a patchwork of MAD implementation schemes across the country. The combination of the volume of applicable resources and the wide variety of people who may seek assistance in retrieving information on their rights and (or) responsibilities (patients, physicians, nurse practitioners, hospital administrators, nurses, police officers, and family members among others) defines the complexity of the research assistance health librarians may need to provide their patrons. This complexity and the unsettled aspects of the law means staying current on law over the next few years will be quite challenging for Canadian health and law librarians—and for our researchers.

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