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Medical Assistance in Dying (MAID) in Canada: Following Bill C-14 through Parliament

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**Medical Assistance in Dying (MAID) in Canada: Following Bill C-14 through
Parliament**

By

Amanda Paige Alchin

A Thesis

Submitted to the Faculty of Graduate Studies
through the Department of Political Science
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts
at the University of Windsor

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2017

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17 May 2017

DECLARATION OF ORIGINALITY

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ABSTRACT

This thesis explores the Government of Canada's legislative response to the *Carter v. Canada (Attorney General)* ruling. More specifically, this thesis analyzes the major issues that afflicted Bill C-14, or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, as it progressed through the House of Commons and the Senate. I utilized a thematic analysis to determine the issues that shaped the debates on Bill C-14 and whether or not they had an impact on the proposed legislation that is now a law. These issues include whether or not Bill C-14 complies with the Supreme Court of Canada (SCC) ruling, if Bill C-14 would adequately protect the vulnerable, and if Bill C-14 would adequately ensure access to medical assistance in dying (MAID). This thesis will further enrich our understanding of a relatively new end-of-life care option in Canada and speculate the future of MAID legislation.

DEDICATION

This thesis is dedicated to Canadians who are at the end of their lives and the health care practitioners who are helping them through life and in death.

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TABLE OF ABBREVIATIONS

Abbreviation	Meaning
AG	Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group)
ALS	Amyotrophic lateral sclerosis
AMA	American Medical Association
BQ	Bloc Québécois
CMA	Canadian Medical Association
CPC	Conservative Party of Canada
GP	Green Party of Canada
JUST	Standing Committee on Justice and Human Rights
LCJC	Standing Senate Committee on Legal and Constitutional Affairs
LPC	Liberal Party of Canada
MAID	Medical assistance in dying
MP	Member of Parliament
NDP	New Democratic Party of Canada
PAD	Physician-assisted death
PAS	Physician-assisted suicide
PDAM	Special Joint Committee on Physician-Assisted Death
PDE	Principle of double effect
SCC	Supreme Court of Canada
SMO	Social movement organization
VAE	Voluntary active euthanasia
VSED	Voluntary stopping of eating and drinking
WLST	Withhold/withholding or withdrawal/withdrawing of life-sustaining treatment

CHAPTER 1

INTRODUCTION

“I am not a hero, either—by my definition, anyway. To me, anyone who does what *should* be done is not a hero... And I still feel that I’m only doing what I, as a physician, should do.” (Kevorkian, 1994, p. 7)

Dr. Jack Kevorkian, who supported voluntary euthanasia, expressed the above sentiment when he received the American Humanist Association’s Humanist Hero Award in 1994 (pp. 9, 7). This sentiment, however, would lead to his ten to twenty-five year prison sentence only five years later (Johnson, 1999, p. A1). He was not only convicted of second-degree murder of a man named Thomas Youk, he also admitted to assisting in the deaths of at least 130 other people. While many applauded the sentence, Thomas’ wife Melody explained that Kevorkian was simply fulfilling her husband’s request (p. A1). Thomas suffered from amyotrophic lateral sclerosis (ALS), and according to Melody, Kevorkian “brought him peace at the end” (pp. A1, A23). This is one case of many that shows the controversy surrounding the topic at study.

Terminology

Manning (1998) states that physicians often differentiate *euthanasia* and *physician-assisted suicide* (PAS) (p. 3). Euthanasia, he explains, refers to someone intentionally ending another person’s life to stop his or her pain (p. 1). *Passive euthanasia* includes the withhold or withdrawal of life-sustaining treatment (WLST), and *active euthanasia* includes the provision of lethal drugs (pp. 4, 3). More specifically, *voluntary active euthanasia* (VAE) occurs when a patient requests and consents to the act, and contrastingly, *involuntary active euthanasia* occurs when a patient did not

request or consent to the act (p. 3). PAS, on the other hand, occurs when a physician gives the patient the lethal method, “but the patient performs the lethal act himself or herself” (pp. 2-3). Despite differences, the objective is always to cause death (p. 3).

This thesis will use the term *physician-assisted death* (PAD) instead of PAS. First, PAD and VAE activists prefer the word *death* to *suicide*. Quill (1994) explains that, in cases of suicide, “the person’s essence is destroyed in the act.” Dying patients, he adds, do not want death but may choose it “to preserve what remains of their personhood” (p. 319). Death with Dignity (n.d.), an Oregon-based organization, would agree, arguing that it is always the underlying conditions that kill the patients—and not the patients themselves—in cases of PAD. Second, the Supreme Court of Canada (SCC) ruling in *Carter v. Canada (Attorney General)* (2015) uses the term PAD significantly more often than PAS. In fact, the ruling held that prohibiting PAD increases early suicides (para. 57-58). Therefore, to remain sensitive to dying patients and consistent with the SCC ruling, PAD will be used in place of PAS.

The bill under study, Bill C-14 or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (2016), uses the more encompassing term *medical assistance in dying* (MAID). This bill, which is now a law, stipulates that s. 241.1 of the *Criminal Code* define MAID. Accordingly, PAD refers specifically to physicians assisting in death whereas MAID refers to both physicians and nurse practitioners assisting in death. Furthermore, PAD refers to a physician’s indirect assistance in dying, and MAID includes both indirect PAD and direct VAE (s. 3). While PAD is more commonly used in the literature and PAD and MAID are often interchanged, this thesis will also use the term MAID when appropriate.

PAD and VAE around the World

Canada is not the first country in which PAD or VAE has become an option for certain patients. The Royal Society of Canada Expert Panel on End-of-Life Decision Making found the following: “The most far-reaching mechanism for changing a regime with respect to assisted death is to decriminalize euthanasia and/or assisted suicide. The Netherlands, Belgium, Luxembourg and the US states of Oregon and Washington have chosen this route” (Schuklenk et al., 2011, p. 76). And considering the strength of the social movement supporting PAD, it is not surprising that a lot of changes have happened since the publication of their report.

These changes are especially apparent in the United States. While no federal laws mandating PAD or VAE exist in the US, seven states have allowed PAD (Collier, 2017, p. E123). This includes the states already mentioned, Oregon and Washington; Montana; Vermont; California; and most recently, Colorado and the District of Columbia (p. E123). Derek Humphrey (as quoted in Collier, 2017), who founded an American right-to-die organization, states that the movement is trying to get PAD legislation passed one step at a time. He added that they are working on Connecticut, New Jersey, and New York next (p. E123).

Moving from the US to South America, Colombia allows VAE. Ceaser (2008) explains that euthanasia was prohibited until the Colombian judiciary lifted the prohibition in 1997. He adds that the court stipulated that a patient must request the act, have no available options for medical treatments, and be terminally ill (p. 290). Nevertheless, it was not until roughly eighteen years later, in 2015, that the health ministry introduced regulations (BBC, 2015, para. 5-6). Switzerland also allows PAD.

Black (2014) states that the country has “a permissive stance toward assisted suicide,” explaining that *any* individual can aid a suicide without prosecution so long as his or her involvement is not selfishly driven (p. 109). There are, however, additional regulations for physicians (p. 110). From North America to South America to Europe, it is clear that PAD and VAE are becoming more and more prevalent.

Based on the above discussion, it can be concluded that there are currently thirteen jurisdictions, including Canada and seven US states, that explicitly allow MAID, PAD, and/or VAE. It is interesting to note that eligibility criteria and procedural safeguards vary across these jurisdictions. Refer to Table 1 below to compare PAD and VAE legislation in the Netherlands, Belgium, Luxembourg, Oregon, and Washington.

Table 1
Comparison of PAD and VAE Legislation in Various Areas

Area	Name of Legislation	PAD or VAE?	Physician required?	Terminal illness required?	Advance requests?
The Netherlands	<i>Termination of Life on Request and Assisted Suicide (Review Procedures Act)</i>	Both	Yes	No	Yes
Belgium	<i>Belgian Act on Euthanasia</i>	Both*	Yes	No	Yes
Luxembourg	<i>Right to Die with Dignity</i>	Both	Yes	No	Yes
Oregon	<i>Death with Dignity Act</i>	PAD only	Yes	Yes	No
Washington	<i>Death with Dignity Act</i>	PAD only	Yes	Yes	No

**Belgian Act on Euthanasia* regulates VAE only; however, PAD is not criminalized in Belgium and the Federal Control and Evaluation Commission stated that PAD is, thus, legal.

Note: Data in table and caption from Schuklenk et al., 2011, pp. 76-83.

For example, as shown above, advance requests for PAD and VAE are available in at least three countries in Europe and are not available in at least two states in the US.

Schuklenk et al. (2011) define the similar term *advance directives* as “one form of advance care planning” wherein a presently competent person states his or her end-of-life preferences before he or she loses competency (p. 18).

It is also interesting to note that laws allowing PAD and VAE have been passed in various ways. In the Netherlands, PAD and VAE are both criminalized, but their laws also state that so long as physicians report their cases and are found to be practicing with due care, they are immune from being prosecuted (Schuklenk et al., 2011, p. 77). While the ability to seek PAD or VAE in Belgium, Luxembourg, and Vermont originated in their legislatures, the ability to seek PAD in Oregon and Washington originated in petitions that resulted in statewide ballots (Lewis, 2015). In Oregon, for example, the ballot was held in 1994; but various obstacles, including court challenges and oppositional federal efforts, led to the *Death with Dignity Act* not being passed until 1997 (Schuklenk et al., 2011, p. 80). The ability to seek PAD and VAE in Montana and Colombia, respectively, began with the judiciaries (Lewis, 2015). And as this thesis will soon explain in more detail, this was the case in Canada as well.

MAID in Canada

A brief recap of the history of MAID in Canada will show that PAD and VAE are not new issues to the Parliament of Canada or the SCC. To begin, prior to the *Carter v. Canada (Attorney General)* ruling in 2015, PAD and VAE were illegal in Canada. The *Criminal Code* (1985) stated:

“Every one who

- (a) counsels a person to commit suicide, or
- (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” (s. 241).

There were, however, various attempts to legalize PAD and VAE in the legislatures and in the judiciary leading up to the SCC ruling and Bill C-14. Refer to Table 2 below to see some of the more recent federal legislative attempts.

Legislative History

Notably, late Bloc Québécois (BQ) MP Francine Lalonde introduced a bill that would amend the *Criminal Code* to allow for PAD in 2005, and her cancer diagnosis inspired her to reintroduce the bill in 2008 (Rodrigue, 2008, A.15). Her efforts persisted the following year (LEGISInfo, n.d., Private member’s bill C-384 (40-2)). Similarly, the Honourable Steven Fletcher, former Conservative Party of Canada (CPC) MP and first quadriplegic cabinet minister, was also inspired by events in his own life when he introduced two bills to allow for and oversee PAD (Duffy, 2014, p. A.10). And lastly, excluding the debates on Bill C-14, the last time PAD legislation was debated in Parliament was June 2, 2015, when the Honourable Senator Nancy Ruth’s Bill S-225 was being considered (LEGISInfo, n.d., Senate public bill S-225 (41-2)).

Table 2
Federal Legislative Attempts to Legalize PAD or VAE between 2000 and 2015

Bill	Date Introduced	Sponsor	Last Stage Completed
C-407 An Act to amend the Criminal Code	June 2005	Francine Lalonde (BQ)	Introduction and First Reading in the House of Commons

(right to die with dignity)			
C-562 An Act to amend the Criminal Code (right to die with dignity)	June 2008	Francine Lalonde (BQ)	Introduction and First Reading in the House of Commons
C-384 An Act to amend the Criminal Code (right to die with dignity)	May 2009	Francine Lalonde (BQ)	Introduction and First Reading in the House of Commons
C-581 An Act to amend the Criminal Code (physician-assisted death)	March 2014	The Honourable Steven Fletcher (CPC)	Introduction and First Reading in the House of Commons
C-582 An Act to establish the Canadian Commission on Physician-Assisted Death	March 2014	The Honourable Steven Fletcher (CPC)	Introduction and First Reading in the House of Commons
S-225 An Act to amend the Criminal Code (physician-assisted death)	December 2014	The Honourable Nancy Ruth	Introduction and First Reading in the Senate

Note: Data in table from LEGISInfo, n.d., Private member’s bill C-407 (38-1); LEGISInfo, n.d., Private member’s bill C-562 (39-2); LEGISInfo, n.d., Private member’s bill C-384 (40-2); LEGISInfo, n.d., Private member’s bill C-581 (41-2); LEGISInfo, n.d., Private member’s bill C-582 (41-2); and LEGISInfo, n.d., Senate public bill S-225 (41-2).

There were also provincial legislative attempts before Bill C-14. The most notable is Bill 52, or *An Act respecting end-of-life*, which was passed by Quebec’s provincial legislature in the winter of 2015 (H. Young, 2016, p. E33). Though the SCC ruling in *Carter v. Canada (Attorney General)* (2015) did not occur until early 2015 and the lifting of the prohibition was also suspended for a year thereafter, Quebec had been working on this legislation for four years (para. 32; H. Young, 2016, p. E33). Bill 52 allows PAD for “extreme cases” whereby patients are terminal, can consent, and are in uncontrollable

pain, among other eligibility criteria (H. Young, 2016, p. E33). Thus, before Bill C-14 was even drafted, at least one provincial legislature prepared for PAD's inevitable reality.

Judicial History

Not surprisingly, discussions on PAD and VAE were not limited to the legislatures. They were also issues brought before the courts. Refer to Table 3 below for a quick summary of relevant SCC cases.

Table 3
Attempts to Legalize PAD or VAE at the SCC

SCC Case	Date of Ruling	Appellant(s)	Ruling
<i>Rodriguez v. British Columbia (Attorney General)</i>	1993	Sue Rodriguez	Appeal dismissed, thus leaving ban on PAD and VAE
<i>R v. Latimer*</i>	1997	Robert W. Latimer	Appeal allowed, thus requiring a new trial for Latimer
<i>R v. Latimer*</i>	2001	Robert W. Latimer	Appeal against conviction and sentence of Latimer dismissed
<i>Carter v. Canada (Attorney General)</i>	2015	Lee Carter, Gloria Taylor, British Columbia Civil Liberties Association, Hollis Johnson, and William Shoichet	Appeal allowed, thus permitting PAD in certain cases

**R v. Latimer* was not necessarily concerned with legalizing PAD or VAE in general, but it is relevant (*R v. Latimer*, 1997, para. 1). These cases are explained within the text below.

Note: Data in table from *Rodriguez v. British Columbia (Attorney General)*, 1993; *R v. Latimer*, 1997; *R v. Latimer*, 2001; and *Carter v. Canada (Attorney General)*, 2015.

One of the most well known cases is *Rodriguez v. British Columbia (Attorney General)* in 1993. Being afflicted with ALS, Sue Rodriguez not only worried about her deteriorating quality of life, she also worried that she eventually would not be able to take her own life in the future (Downie & Bern, 2008, p. 29). Consequently, in the winter of

1992, she went to the British Columbia Supreme Court to challenge the *Criminal Code*'s PAD prohibition on grounds that it breached her rights under the *Canadian Charter of Rights and Freedoms*. Her case eventually went to the SCC, where, in the fall of 1993, the majority ruled against her claim (p. 29).

More specifically, Browne and Russell (2016) explain that the SCC ruled that the prohibition breached people with disabilities' s. 7 liberty rights due to their inability to commit suicide and s. 7 security rights due to their inevitability of unfavourable deaths. However, the SCC ultimately ruled that the prohibition existed in light of the principles of fundamental justice, specifically that it "protects the vulnerable from abuse or misuse" (p. 378). Little did Rodriguez know that just over twenty years later, this ruling would be overturned in *Carter v. Canada (Attorney General)* in 2015.

Before that though, another SCC case that became well known and is relevant to this topic was *R v. Latimer* in 2001. Tracy Latimer was a 12-year-old girl from Wilkie, Saskatchewan who suffered severe cerebral palsy (Guy, 2003, p. 487). In addition to being quadriplegic and having at least five seizures a day, Tracy was in uncontrollable pain (pp. 487-488). She had many surgeries and would have many more. And one of the surgeries she was scheduled to have, according to Tracy's mother, led Tracy's father Robert to thinking that Tracy's "life was no longer worth living." Just over a month before the surgery, Robert put Tracy in his truck and used the truck's exhaust pipe to induce carbon monoxide poisoning (p. 488).

Originally charged with first-degree murder, Robert was subsequently found guilty of second-degree murder in 1994, and he unsuccessfully appealed to the SCC in 1997 and again in 2001 (Guy, 2003, pp. 488-489, 487). Robert tried to use "the defence

of necessity[,]” which Guy defines as “a common law excuse that is available to an accused when he or she acted in response to an urgent and imminent peril that could not have been avoided by obeying the law” but was, as previously mentioned, unsuccessful (p. 486). Throughout, he referred to his actions as “an act of mercy” and has received support from all across Canada (Cowan, 2010).

This type of support would eventually appear in the SCC with *Carter v. Canada (Attorney General)* in 2015. Plaintiffs Kay Carter and Gloria Taylor both suffered degenerative diseases (Payton, 2015, para. 10). The B.C. Civil Liberties Association brought the case forward, arguing that, like Rodriguez, “they were being discriminated against because their physical disabilities didn’t allow them to kill themselves the way able-bodied people could” (para. 11). Unfortunately, both women died before the ruling. Carter received PAD in Switzerland, and Taylor succumbed to ALS (para. 10, 12). Nevertheless, it was in this SCC case that the ruling in *Rodriguez v. British Columbia (Attorney General)* was reconsidered and the prohibition on PAD was lifted.

This important ruling and its impact will be explained in more detail in Chapter 4. In summary, onus was henceforth placed on the legislatures, notably the Parliament of Canada, to pass legislation to regulate the practice—a practice now deemed a *Charter* right for eligible Canadians. Accordingly, the Minister of Justice introduced Bill C-14 on April 14, 2016 (LEGISinfo, n.d., House government bill C-14 (42-1)). And though the government held a stable majority, Bill C-14’s passing was not guaranteed due to the declaring of a free vote (Wherry, 2016, para. 2). Ultimately, Bill C-14 received Royal Assent on June 17, 2016 (LEGISinfo, n.d., House government bill C-14 (42-1)).

Outline

As explained in the Abstract, this thesis explores the Government of Canada's legislative response to the *Carter v. Canada (Attorney General)* ruling. Its objective is to identify key areas of concern as Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, progressed through the House of Commons and the Senate. This thesis utilized a thematic analysis to determine the issues that shaped the debates on Bill C-14 and whether or not they had an impact on the proposed legislation that is now a law. These issues include whether or not Bill C-14 complies with the Supreme Court of Canada (SCC) ruling, if Bill C-14 would adequately protect the vulnerable, and if Bill C-14 would adequately ensure access to medical assistance in dying (MAID). This thesis will further enrich our understanding of a relatively new end-of-life care option in Canada and speculate the future of MAID legislation.

This thesis is divided into five chapters. In Chapters 1 and 2, I discuss MAID, PAD, and VAE broadly. In Chapter 1, I seek to introduce the reader to MAID, PAD, and VAE. I briefly discussed terminology, notably the differences between VAE, PAD, and MAID; jurisdictions in which PAD or VAE are permitted; and legislative and judicial history concerning MAID in Canada leading up to *Carter v. Canada (Attorney General)*. In Chapter 2, I want to familiarize the reader with why this topic is so controversial. Hence, this chapter includes a literature review that highlights the ethical, legal, and political dimensions of PAD and VAE.

In Chapters 3, 4, and 5, I discuss my research. In Chapter 3, I describe my sources and methods, notably the Hansard and thematic analysis. Chapter 4 is divided into two

parts. First, I explain the *Carter v. Canada (Attorney General)* ruling and its impact on the legislatures in more detail. I also provide basic information about Bill C-14 or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. Second, I present my findings, which are divided into three themes or issues: constitutionality, ensuring consent, and ensuring access. Lastly, in Chapter 5, I conclude my thesis. I summarize my thesis, including the limits and significance of my research. I also discuss Bill C-14's impact thus far and various events that have transpired since its passing.

CHAPTER 2

LITERATURE REVIEW

Medical assistance in dying (MAID) is an option that most of us hope we never need to consider. In a time of ceaseless advancements in medicine, however, many of us may be kept alive long enough for the option to become favourable. Whether this option *should* be available to us is part of a longstanding debate that is evident in the literature. This debate consists of ethical, legal, and political dimensions that will be discussed in the pages that follow. Before the literature can be reviewed, however, three items must be addressed.

First, the term MAID is not nearly as frequently used as the terms physician-assisted suicide (PAS), physician-assisted death (PAD), and voluntary active euthanasia (VAE). This is especially true in the literature. Since, as noted in Chapter 1, there are differences between these terms and MAID encompasses both PAD and VAE, I will mostly use the terms PAD and VAE to stay true to the words of the scholars that will be discussed and to distinguish between these two medical acts. Nevertheless, these debates are just as relevant to and can be applied to MAID. Second, PAD is not as frequently used as PAS, especially in older literature, but as noted in Chapter 1, I will be using the word death in place of suicide. Hence, if a scholar uses the term PAS, I will be using the term PAD when discussing his or her work. Third, many of the scholars cited are from the United States. While national context affects the literature, many of the topics discussed are internationally applicable.

Ethical

Active Versus Passive Actions

Many scholars debate whether a health care practitioner's actions in assisting death are 'active' or 'passive.' Since few would dispute that the health care practitioner plays an 'active' role in VAE, the literature on this topic predominantly focuses on PAD.

PAD vs. WLST

Quill (1994) describes his role as a physician as helping people (p. 315). Diane was one of those people. Fearing death from acute myelomonocytic leukemia, Diane obtained a lethal prescription and an agreement to meet with him prior to its use. Three months later, Diane met Quill with a rash, pain, and sepsis, leading him to predict that she would succumb to her illness in less than a week. Instead, Diane died on her own terms a couple of days later (p. 318). When expanding on his role in helping people, Quill adds that it "involves helping patients face death, and infrequently it means helping them find [it]" (p. 316).

While Quill (1994) may have helped Diane with the latter, she died on her own to prevent legal risks for him and her family (p. 318). Notwithstanding the law, however, Quill recalls his encounters with Diane as indistinguishable from his encounters with patients who chose the legally permissible route of withholding or withdrawing life-sustaining treatment (WLST) (pp. 318-319). The difference in legal permissibility is rooted in a distinction often made between active and passive actions. Whereas the actions of a physician assisting Diane would be considered 'active,' or causing death; the actions of a physician withdrawing life-sustaining treatment would be considered

‘passive,’ or letting the patient die from the illness (Rachels, AMA, & Wanzer et al., as cited in Quill, 1994, p. 322).

Many scholars note that the distinction is sharp in the books but not in hospital. According to Quill (1994), “from the bedside, this distinction is much less sharp and more ambiguous than many ethicists would like it to be” (p. 322). Thomson (1999), Dworkin (1999), and Brock (1999) show the blurriness of this distinction when discussing WLST. Thomson (1999) is skeptical that a physician simply *lets* his or her patient die when he or she withdraws said patient from life-sustaining treatment. She uses the verb “intervene” to describe the physician’s actions (p. 501). Dworkin (1999) argues that the physician does, indeed, cause the patient’s death by knowing that it is inevitable (p. 584). Irrespective of actions and knowledge of outcomes, another scholar compares WLST and PAD.

Brock (1999) turns to physicians’ intentions in events of WLST and PAD to determine why one is deemed ethically permissible and the other is not, but to no avail (pp. 531-533). Some hold that WLST is ethical on the ground that physicians are only adhering to their patients’ requests and do not want their patients to die. Some also hold that PAD is unethical on the ground that physicians want their patients to die (p. 531). Brock argues that physicians’ intentions can be multifaceted. In events of WLST, the physician may want to adhere to the patient’s requests, but that does not mean the physician does not have other intentions (pp. 532-533). In fact, when surveyed about events of another process, terminal sedation, almost 40% of physicians claimed that death was a goal (Wilson et al., as cited in Brock, 1999, p. 533). In events of PAD, physicians may not necessarily want their patients to die, but rather, they may want them to be

content knowing that they can escape from pain if needed (Brock, 1999, pp. 535-536).

Manning (1998) would disagree, explaining that in both PAD and VAE, “the moral intent is the same—the premature death of the patient” (p. 3).

Nevertheless, Thomson (1999) and Dworkin (1999) also discuss physicians’ intentions in events of PAD and corroborate much of Brock’s (1999) article. Some patients hold onto their lethal prescriptions, but they may not actually fill and ingest them (Thomson, 1999, p. 506; Dworkin, 1999, p. 584). According to Dworkin (1999), physicians may believe that having “such control will make it unnecessary for the patient to actually kill herself” (p. 584). Even in the event that the patient takes the drugs and dies, however, Thomson (1999) still argues that it is the patient who is solely responsible for his or her own death (p. 506). In sum, some scholars speculate if physicians’ intentions can be as clear as the ‘active’ and ‘passive’ distinction between PAD and WLST make it seem.

PAD vs. Pain Control

A discussion of physicians’ intentions being multifaceted would not be complete without a discussion of the principle of double effect (PDE) and administering analgesics. Billings (2011) offers a definition of PDE: “[I]t states that running the risk of a bad outcome is acceptable when we intend to produce a good outcome and when taking the risk of the bad outcome seems sensible” (p. 437). For example, administering morphine to a patient may help with his or her breathing problems, but it may also cause respiratory depression and hasten death at the same time (pp. 437-438). Scholars note that administering analgesics is legally accepted on the basis of PDE, but some question if it

is logical or ethical to do so (see Billings, 2011; Brock, 1999; Thomson, 1999; and Quill, 1994).

Billings (2011) examines four of five conditions of PDE. One of the conditions is to ensure that the act is moral, but the principle does not itself establish what is moral or immoral (p. 438). Conditions two and three require ensuring the intending of a good effect and the foreseeing but not intending of a bad effect, but the principle does not itself establish what are good and bad effects. For example, to some, avoiding a painful death, which may require hastening death, may be a good effect; but to others, hastening death is always seen as bad (pp. 438-439). The last condition requires ensuring the good effect is greater than the bad. This is, again, hard to do (p. 439). Billings concludes that PDE is not substantial enough to accept or reject certain medical acts. He suggests additional moral theories to do so (p. 437).

Thomson (1999) and Brock (1999) also question the simplicity of the application of PDE. Thomson (1999) asks why death is always deemed a 'bad' effect. She believes this is especially contradictory when dealing with patients who request PAD since, in these cases, death is wanted and would be a 'good' effect (p. 511). Moreover, Thomson asks why intending death is always 'bad.' There may be 'good' reasons to intend death, such as satisfying a patient's request (p. 514). Brock (1999) also shows, yet again, that the distinction between active, or illegal actions, and passive, or legal actions, is not so sharp. He suggests the likely scenario of morphine being administered with the intention of causing death, but at the same time, its dosage not increasing in ways that go beyond relieving pain in an effort to avoid legal risks (p. 534).

Quill (1994) provides an example that illustrates this distinction. In order to prevent individuals who have lung cancer from suffocating, physicians administer morphine in doses high enough to relieve the patient but low enough to not cause death. Consequently, even when the patient may suddenly feel like he or she is suffocating and has requested death in the past, the physician is forbidden to give strong enough doses to kill him or her. Quill, as a physician, describes this action as keeping patients “at the agonizing edge of death” (p. 323). Scholars, thus, question whether PAD is similar to other clinical acts apart from its legal status.

Some scholars, however, do see the difference and advocate pain control as an ethical alternative to PAD and VAE (see Kelly, 1995 and Orr, 2001). Kelly (1995) states that even if analgesics “actively” lead to death, Roman Catholic ethics, which is staunchly opposed to killing, supports their use (p. 182). He then addresses some of the ethical arguments against pain control. In response to those that stress the addictive properties of analgesics, he argues that addiction is seldom and “is morally irrelevant in the case of a dying patient” (pp. 182-183). In response to those that see pain control as immoral because it hastens death, he states that Roman Catholic ethics and the American judiciary permits it as “indirect killing” (p. 183). Clearly, scholars disagree on how ‘active’ or ‘passive’ a health care practitioner is in PAD versus pain control.

PAD vs. VAE

As previously noted, MAID encompasses both PAD and VAE. However, even some supporters of PAD staunchly oppose VAE. This includes Quill, Cassel, and Meier (1992) who advocate legalizing PAD *only* (p. 1380). They differentiate between PAD and VAE by referring to a physician providing VAE as an “actual agent of death” (p. 1381).

They also differentiate them legally in favour of PAD, adding that VAE is banned throughout the US but PAD is only prohibited in thirty-six states.¹ Though Quill et al. state that “both involve the active facilitation of a wished-for death,” again drawing on the active and passive notions, they also list differences that they believe make PAD more ethically permissible than VAE (p. 1381).

Quill et al. (1992) argue that there is somewhat of a power balance in cases of PAD that is not likely or perhaps even possible in cases of VAE. They explain:

“[In cases of PAD,] [t]he physician is counselor and witness and makes the means available, but ultimately the patient must be the one to act or not act. In voluntary euthanasia, the physician both provides the means and carries out the final act, with greatly amplified power over the patient and an increased risk of error, coercion, or abuse” (p. 1381).

And though they acknowledge that permitting PAD but not VAE is unfair to people with disabilities, they also argue that VAE is simply too risky. This is especially the case in the US, they add, where relationships between the physician and the patient are often impersonal and medical care is not evenly available (p. 1381). A more thorough discussion of the possibility of risk and abuse will occur in the next subsection.

Battin (1991) briefly draws on the active, or being directly involved, and passive, or being indirectly involved, notions when she differentiates PAD and VAE. With PAD, she argues, “the physician is involved, but not directly; and it is the patient’s choice, but the patient is not alone in making it” (p. 305). Battin refers to some of the same examples Quill et al. (1992) also gave, including the increasingly impersonal relationships between physicians and patients, to advocate against legalizing VAE (p. 1381; Battin, 1991, p.

¹ Please note that this article was published in 1992.

302, 305). Thus, like Quill et al. (1992), Battin (1991) sees the physician as playing more active, or direct, role in VAE compared to PAD, and for this reason, one is preferred over the other.

Though Manning (1999) has doubts about this difference himself, he states that some physicians differentiate between PAD and VAE as well, with surveys showing that physicians are generally more likely to assist in death than to cause it (p. 3). The literature shows that he is right. For example, Anneser, Jox, Thurn, and Borasio (2016) conducted a survey of medical students from the Technical University Munich in Germany (p. 1). Out of the respondents, 51.2% supported PAD, 19.2% considered VAE to be ethically permissible, and 56.9% opposed VAE altogether (p. 3). They also add that the 19.2% belief that VAE is ethically permissible has been consistently supported in other studies (p. 5). In 2009, Zenz et al. (as cited in Anneser et al., 2016) conducted a survey, whereby 32.1% of responding physicians supported VAE (p. 5). Thus, some scholars, students, and health care practitioners think that there are ethical differences between PAD and VAE, making them support the former and not the latter.

Dixon (1998) argues that there is no ethical difference between PAD and VAE. In order to do this, he uses arguments from the Quill et al. (1992) and Battin (1991) articles discussed above, among others, to show that the same arguments used against VAE can be applied against PAD (p. 25). One of the major arguments he counters is that the patient actively causes his or her own death, not the physician, in cases of PAD unlike VAE. This, in turn, decreases the risk of coercion from the physician. Whether self-ingested or physician-injected, Dixon argues, a patient's control is about the same in both: "The only moment when the patient has more control over her destiny in physician-

assisted suicide than in active euthanasia is the split second between the insertion of the needle and the depression of the plunger” (p. 26). Dixon, thus, does not see the patient being more or less active in PAD versus VAE.

Furthermore, Dixon (1998) argues that the physician *does* play an active role in PAD. First, his or her knowledge and means is necessary for the patient to die. Second, in providing knowledge and means, he or she intends for the patient to die (p. 27). As previously mentioned, Manning (1998) agrees that, in cases of PAD and VAE, the objective is the same: death (p. 3). Dixon (1998) then counters traditional arguments against VAE and applies them to PAD. The argument that “killing is wrong because human life is sacred” can also be used against PAD. If this is true, he argues, then assisting someone in doing it to himself or herself is also wrong. The argument that physicians cure—not kill—their patients can also be used against PAD for the same reasons explained (p. 29). Some scholars, like Dixon (1998) and Manning (1998), question whether physicians are as ‘passive’ in cases of PAD versus VAE that some others make it seem.

The Slippery Slope

Some scholars think that a total prohibition of PAD and VAE is the only way to protect the vulnerable. Meanwhile, others think that eligibility criteria and procedural safeguards can prevent risk and abuse. While many of the scholars refer to PAD specifically, many of the arguments can often be applied to VAE and thus MAID.

Confining PAD and VAE

Many scholars doubt that PAD would experience more abuse than WLST (see Brock, 1999 and Dworkin, 1998). Meanwhile, other scholars fear that legalizing PAD or

VAE would lead to a slippery slope (see Arras, 1996-1997; Kamisar, 2012; Traina, 1998; and Emanuel, 1999). Arras (1996-1997) identifies two arguments concerning a ‘slippery slope’: “one bears on the inability to cabin PAS/euthanasia within the confines envisioned by its proponents, the other focuses on the likelihood of abuse, neglect, and mistake” (p. 368). First, PAD opponents doubt that limiting PAD to terminally ill, mentally competent individuals who are suffering intolerably is possible (p. 369). Second, PAD opponents also doubt that any proposal will result in a practice that is free from risk and abuse (p. 370). Multiple sides are evident in the literature.

To provide a sufficient transition from the previous subsection, I will begin with those scholars that argue abuse is just as, if not more likely, in events of WLST than PAD. Both Brock (1999) and Dworkin (1998) disagree that PAD cannot be confined. Brock (1999) lists the safeguards typically used, such as limiting eligibility to adults and ensuring the exhaustion of all alternatives. And while he acknowledges that these safeguards cannot prevent all abuse, he argues, “the status quo... is not free of abuse either” (p. 540). More specifically, physicians still assist in death in states that have banned the practice, but worse, they do so covertly and freely. He also adds that these safeguards are not formally enforced in events of WLST, administration of analgesics, and terminal sedation yet they all of these acts end in death (p. 540). The predicted effectiveness of safeguards, or lack thereof, will be returned to later in this section.

Brock (1999) and Dworkin (1998) also address the argument that PAD cannot be confined in terms of scope. PAD opponents argue that PAD is likely to be more popular than WLST because patients do not need to be on life support to be eligible (Brock, 1999, p. 541). Both scholars note that safeguards would significantly limit who is eligible (p.

541; Dworkin, 1998, p. 136). Both scholars also point to empirical evidence that shows that more patients in the Netherlands, where PAS and VAE has been legal for a long time, opt for WLST over PAD. Brock (1999), using a Rummelink study from the 1990s, stated that 17.6% more patients died from WLST than from PAD and VAE (p. 541). Dworkin (1998) stated that roughly 18,800 more patients die from WLST than PAD and VAE (p. 136). Thus, Brock (1999) and Dworkin (1998) both fail to see how PAD and VAE cannot be confined in comparison to WLST.

Arras (1996-1997), on the other hand, doubts it is logical or even possible to limit PAD considering arguments for PAD are predicated on personal autonomy (p. 369). Kamisar (2012) would agree. First, Kamisar quotes Chief Justice Rehnquist in *Cruzan v. Director, Missouri Department of Health*, a case that confirmed a mentally competent patient's right to WLST (p. 68). Rehnquist stated that this verdict was not based on ideas of autonomy; rather, it was based on the idea that involuntary medical intervention is wrong (p. 69). Second, Kamisar predicts that the logic behind legalizing PAD on the ground that WLST is legal will result in a practice that cannot be confined to terminally ill patients:

“If... *terminally ill* people *off* life support are entitled to control the time and manner of their deaths because they are “similarly situated” to terminally ill people *on* life support who do have such a right because they can reject life support — it seems to follow that *non-terminally ill* people who *do not need any* lifesaving medical treatment are entitled to control the timing of their deaths... because they are “similarly situated” to *non-terminally ill* patients who *do need*

but may reject life-sustaining medical treatment and thereby control the timing of their deaths” (p. 69).

While Arras (1996-1997) and Kamisar (2012) predict the unlikelihood or even impossibility of confining PAD, the next three scholars that will be cited focus on the second ‘slippery slope’ argument.

Risk and Abuse

Brock (1999) addresses this argument in light of WLST. He states that if it is agreed that abuse stems from lack of consent, abuse could only be detected in events where a patient did not consent. And due to the presence of surrogate decision-making in events of WLST, administration of analgesics, and terminal sedation, Brock concludes that abuse is more likely in those events than in events of PAD (p. 539). Traina (1998) and Emanuel (1999), conversely, show how patients may request and attain PAD and VAE but not for the right reasons.

Traina (1998) uses feminist thought to argue that women and the lower classes will be more likely to request death (pp. 1152-1154). Sherwin (as cited in Traina, 1998) argues that physicians treat women and men differently. For example, physicians misdiagnose women more often than men (p. 1152). Traina (1998) contemplates whether physicians, who often treat women’s issues with less vigour than men’s, will grant women death without exhausting all alternatives (pp. 1152-1153). She finds this especially concerning in a time of cost-cutting measures (p. 1153). Other feminist arguments are mentioned, but Fulkerson and Nussbaum (as cited in Traina, 1998) turn us to class-based assumptions (p. 1153). Traina (1998) contemplates whether the lower classes will become victims as well due to their lack of medical care while the wealthy

few can “be made more comfortable in death” and thus less likely to request it (p. 1154). It is feared that class will make one more susceptible to PAD or VAE. Emanuel (1999) has this fear too. However, it should be noted that, due to our provincial and territorial health care plans, this fear is not totally perceived in Canada.

Emanuel (1999) tries to weigh the benefits and harms of legalizing PAD and VAE. First, he examines the potential benefits. While he argues that having safeguards means autonomy is never fully realized, he also estimates that between five thousand and twenty-five thousand patients will benefit from PAD and VAE annually and its legalization will make 40% of Americans feel better about death (pp. 630-635). Second, Emanuel examines the potential harms. Not only have studies shown physicians regretting events of PAD and VAE, studies have also suggested that many patients may be driven into requesting death due to “financial or caregiving burdens” and some patients may not be mentally competent when doing so (pp. 636-640).

Emanuel (1999) concludes that the “financially well-off, well-educated, white, nonreligious, and [those] under sixty-five years of age” will likely benefit from legalizing PAD or VAE due to their likelihood of having medical insurance; and the lower classes, especially African Americans and women, will be more likely to experience the harms and request death (pp. 641-642). Consequently, Emanuel is skeptical if legalizing PAD and VAE will be beneficial (p. 642). Thus, a scholar’s support or opposition of MAID is often based on an ethical dilemma between compassion for those suffering intolerably and fear of abuse of the vulnerable.

Legal

Court Challenges

This ethical dilemma is hotly debated at dinner tables and in supreme courts around the world. The literature on these cases is extensive, so in an effort to narrow the scope, this subsection will focus on legal arguments for and against PAD and VAE in two countries: Canada, the focus of this thesis, and the US, our neighbour and, as discussed in Chapter 1, a country where PAD is currently and increasingly becoming a reality.

Canada

Legal Tradition

MacFarlane (2014) and Martel (1998) both examine how PAD challenges Canadian legal tradition. MacFarlane (2014) argues that the Supreme Court of Canada (SCC) has traditionally taken a “negative rights approach” when interpreting the *Charter of Rights and Freedoms* but, in doing so, has supported “logic that has obvious positive rights implications” (p. 50). While negative rights inhibit government interference, positive rights necessitate government inference (p. 49). MacFarlane provides a survey of cases concerning what he deems positive rights, namely sections 15 and 7, and discusses why the courts may be hesitant to impose such rights, such as their unwillingness to force budgetary duties on governments (pp. 51-55, 58-59). Nevertheless, MacFarlane warned that if the SCC did not grant a positive right to PAD, provinces might find ways to restrict access to it (p. 69). He suggested treating PAD as exceptional to legal tradition (p. 51). Despite his argument, he cites a study by Billingsley and Carver of s. 7 cases, several of which advanced positive rights claims, specifically ones that called for legal counsel to be funded by the government (p. 54).

MacFarlane (2014) discusses the *Rodriguez v. British Columbia (Attorney General)* ruling in 1993 and *Carter v. Canada (Attorney General)* that began in 2012. In 1993, the prohibition on PAD was supported on the grounds that section 7 of the *Charter* applies to society, not just the plaintiff, and that a prohibition protects the latter. In 2012, the prohibition was rejected on the grounds that it violates sections 7 and 15 of the *Charter*. MacFarlane predicted, in 2014, that differences between the two cases, such as the accumulation of experiences from areas that have legalized PAD since 1993, might make *Carter v. Canada (Attorney General)* influential and exceptional (p. 68).

In fact, Karsoho, Wright, Macdonald, and Fishman's (2017) recent research confirms MacFarlane's (2014) prediction. They explain that the plaintiffs in *Carter v. Canada (Attorney General)* used expert evidence and experiences from jurisdictions that have permitted PAD, including the Netherlands, Belgium, and Oregon (Karsoho et al., 2017, p. 49). Karsoho et al. argue that this was done to demonstrate that permitting PAD with sufficient safeguards and protecting the vulnerable are not mutually exclusive actions (p. 55).

Martel (1998) also examines how *Rodriguez v. British Columbia (Attorney General)* challenged legal tradition (p. 131). Sue Rodriguez was the first person in Canada to challenge the distinction between attempting to commit suicide, which is legal, and assisting someone in committing suicide, which was illegal (pp. 135-136). Due to the lack of consensus and legal precedent on PAD at the time, Martel argues that she "faced a court apparatus that was ill-equipped to respond to... her demands" (pp. 141-142). Martel then concludes that the verdict in this case is indicative of judges' tendencies "to reinforce the *status quo*" (p. 153). However, she also concludes that the slim majority is

indicative of just the beginning of inquiring of the law (p. 154). Because the debate on PAD and VAE has resurfaced since the publication of her article, it is clear that she was right.

The Constitution

Some scholars illustrate this inquiry (see Downie & Bern, 2008). Downie and Bern (2008) argue that, in light of changes since *Rodriguez v. British Columbia (Attorney General)*, a prohibition on PAD violates section 7 of the *Charter* (p. 28). Schafer (2013) corroborates some elements of their article in his references to *Carter v. Canada (Attorney General)* (p. 522). Downie and Bern (2008) begin with other ways to challenge PAD prohibitions, such as “prosecutorial discretion” and “jury nullification[,]” but they ultimately suggest a constitutional challenge (p. 31). Similarly, Schafer (2013) notes that the Canadian legal system tends to be lenient when it comes to sentencing those convicted of assisting in death, but he ultimately argues that a constitutional prohibition on PAD cannot be supported (p. 523, 530).

First, some scholars give contextual reasons as to why a prohibition cannot be supported. Downie and Bern (2008) note that general consensus supports a constitutional challenge. Canadians wholly support decriminalization; the Canadian Medical Association (CMA) does not necessarily reject legalization; medical associations elsewhere support the practice; and studies of other areas that have legalized the practice do not support slippery slope arguments (pp. 32-39). Schafer (2013) also notes that only one-third of Canadians did not support legalization of PAD in 2011 (p. 522). Attaran (2015) discussed this consensus after *Carter v. Canada (Attorney General)*, adding that

almost eighty percent of Canadians agreed with the lifting of the PAD prohibition (p. 2080).

Second, some scholars refer to legal precedent to explain why a prohibition cannot be supported. Downie and Bern (2008) note that cases since 1993 would also support this challenge. These cases include those that redefined section 7 of the *Charter*, which is seen in the SCC cases *R v. Marmo-Levine* in 2003 and *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)* in 2004 (pp. 39-42). These three scholars conclude that a prohibition on PAD could not be supported due to the redefinition of this right and experiences of other countries (Downie & Bern, 2008, pp. 28, 36; Schafer, 2013, pp. 524-525, 530). And they were right—this prohibition was ultimately lifted in *Carter v. Canada (Attorney General)* in 2015.

New Arguments

Not surprisingly, given how significant this ruling is, literature on *Carter v. Canada (Attorney General)* is becoming ample. Browne and Russell (2016) note the significance of the ruling not only for Canada but also for countries around the world. They also note the significance of the ruling on the debate on PAD and VAE in general (p. 377). They argue that the SCC ruling recognizes two new arguments. First, though this argument emerged with *Rodriguez v. British Columbia (Attorney General)*, it is now recognized “that prohibiting PAD discriminates against the disabled in that it treats those who are not physically able to end their lives from doing what able-bodied people legally can” (p. 380). Second, instead of using the typically cited arguments that are based on values like autonomy, it was argued and is now recognized that PAD should not be prohibited because it may lead to individuals, who fear future pain, prematurely ending

their lives. Browne and Russell point to how unusual it is that “fresh arguments” can emerge surrounding such an old debate (p. 380).

Karsoho et al. (2017), using trial transcripts and other materials from the SCC ruling, examine the arguments of both the plaintiffs and defendants (p. 48). For example, the plaintiffs and their expert witnesses insisted that a patient seeking PAD may not be mentally ill and stressed the difference between PAD and suicide (p. 51). Meanwhile, the defendants insisted that a patient seeking PAD is suicidal and needs mental health intervention—not PAD (p. 50). Karsoho et al. conclude that the *Carter v. Canada (Attorney General)* ruling, in decriminalizing PAD, “has contributed to the production and reproduction of a specific cultural script that renders deaths from PAD ‘culturally appropriate’” (p. 55). It is clear, then, that the SCC ruling contributes to the longstanding debate on PAD and VAE.

The United States

Like Canada, there are arguments that MAID should be permitted or not permitted in the US that go beyond ethical concerns. Fraser and Walters (2000) discuss the four principles at play in court challenges against PAD prohibitions (p. 121). The first principle is autonomy. They argue that a prohibition is contrary to the liberty interest that is contained in the Fourteenth Amendment of the Constitution. The second principle is justice. They argue that a prohibition means some individuals can end their suffering while others are often too disabled to do so. The third principle is democracy. They argue that a prohibition is more likely to be supported by the wealthy minority (p. 123). The last principle is liberty. Citing judges in *Compassion in Dying v. State of Washington* and the multiplicity of religions in the US, they argue that religious beliefs should not contribute

to the practice, or rather lack thereof, of PAD but that they often do (pp. 123-124). Fraser and Walters, among others, conclude that prohibiting PAD is contrary to these legal principles (p. 121).

Other scholars evoke these principles when discussing US Supreme Court decisions *Washington v. Glucksberg* and *Vacco v. Quill* (see Chemerinsky, 2008 and McKenzie, 2004). In these cases, bans in Washington and New York, respectively, were deemed not unconstitutional (McKenzie, 2004, p. 787). In *Washington v. Glucksberg*, Chief Justice Rehnquist justified the decision by noting the law's denunciation of assisting death, citing "English common law, Blackstone's commentaries, and colonial law[;]" explained that the Due Process Clause can only be extended in certain decisions; and brainstormed the state's interests, such as protecting life, and their incompatibility with PAD (pp. 788-789). In *Vacco v. Quill*, Rehnquist confirms the distinction between WLST and PAD (p. 790). Despite this line of reasoning, Chemerinsky (2008) calls the decisions in these cases "tragically wrong" and evokes the principle of autonomy (pp. 1502-1503).

Chemerinsky (2008) argues that autonomy, and by extension a right to PAD, is constitutionally protected as a right to privacy (p. 1503). He defines this right: "[for] individuals to have the autonomy to make crucial decisions concerning their lives" (p. 1507). Though originalists may state that the Constitution does not explicitly provide a right to privacy, Chemerinsky states that there are reasons to believe that the Supreme Court has recognized this right well before *Washington v. Glucksberg* (p. 1504). He gives examples: "the right to marry" in *Loving v. Virginia*, "the right to custody of one's children" in *Santosky v. Kramer*, and more (p. 1503). Chemerinsky also states that

deciding one's death is as important, and perhaps more foundational, to fulfilling autonomy as, and than, these examples (p. 1507).

McKenzie (2004) agrees that these court decisions violate a vital principle, specifically the principle of liberty (p. 788). McKenzie does so on the grounds that the decisions were justified via Christian beliefs (p. 788). McKenzie first summarizes Judge Reinhardt's decision, namely that prohibiting PAD violates the Establishment Clause, in the Ninth Circuit Court of Appeals (p. 791). For example, Reinhardt does not see a difference between WLST and PAD (p. 794). McKenzie, however, is more concerned with Reinhardt's *explicit* religious references because of his insinuation that "if not for religion... there is no legitimate reason to ban PAS" (p. 797).

McKenzie (2004) then analyzes three scholarly critiques of Reinhardt's Court Opinion (p. 797). For example, O'Mathuna and Amundsen (as cited in McKenzie, 2004) state that Reinhardt's claim that suicide is not denounced in the Bible is inaccurate (pp. 799-800). McKenzie (2004) accuses them of wrongly insinuating that Reinhardt stated that the Bible not only denounced suicide but supported it too (p. 801). And lastly, McKenzie notes that while religious groups still oppose PAD, Harris Polls have shown society's support increasing over twenty years (pp. 806-807). Since Reinhardt's decision endures scholarly critiques and society is increasingly accepting of PAD, McKenzie concludes that the reversal of the Ninth Circuit's decision was wrong (pp. 808-809).

Kamisar (1997-1998) justifies the reversal. Responding to the Ninth Circuit's decision that deaths from WLST are not any more or less natural than deaths from PAD, Rehnquist upheld the distinction (pp. 899-902). He did so on grounds that it is based on its support in the medical field and presence in legal history (p. 902). Chemerinsky

(2008) does not agree with the weight Rehnquist attributes to history; he uses past examples, such as allowing abortion in *Roe v. Wade*, to show that the Supreme Court has based their decisions on tradition before (pp. 1504-1505). Nevertheless, the plaintiffs also argued that *Cruzan v. Director, Missouri Department of Health* was a case that extended beyond WLST to recognize autonomy and thus PAD (Kamisar, 1997-1998, pp. 902-903). Rehnquist, however, did not see the connection (p. 903). In sum, while some scholars note incompatibility between prohibitions on PAD and legal principles, others note the prohibitions' consistency with American legal tradition.

Political

While MAID is a topic that will inevitably touch the lives of many Canadians, there are three groups of individuals that the literature focuses on: patients, the medical community, and social movement organizations (SMOs). For the purposes of this thesis, more time will be spent discussing patients and health care practitioners.

Patients

“Heartwrenching Cases”

Chereminsky's (2008) father was a patient that requested PAD; and though he was bedridden, in significant pain, and dying from terminal lung cancer, he was denied it (p. 1501). Even fifteen years after his death, Chemerinsky still did not know “what interest the State of Indiana... had in keeping him alive” (pp. 1501-1502). While Kamisar (1998) states that even the staunchest of PAD opponents have sympathy for these “heartwrenching case[s,]” he also argues that there will be victims in the presence of a

prohibition or lack of one (p. 1123). It is no surprise, then, that support and opposition for the legalization of PAD often turns into mobilized political efforts.

General Consensus

Some scholars focus on the dying patients themselves or their caregivers to add to the growing evidence that the most directly affected portion of the public supports PAD and VAE (see Wilson et al., 2007; Breitbart et al., 2000; Emanuel, Fairclough, & Emanuel, 2000; and Tomlinson, Spector, Nurock, & Stott, 2015). Using Canadian National Palliative Care Survey interviews of cancer patients from 2001 to 2003, Wilson et al. (2007) found that, of the 379 participants, 238 (62.8%) supported laws allowing VAE and/or PAD (p. 314). And ninety-nine participants (26.1%) opposed both (p. 316). Breitbart et al. (2000) also conducted a survey of cancer patients. They found that, of the ninety-two participants, sixteen (17%) desired a hastened death (p. 2907). Literature, thus, shows support for MAID among patients that would likely be eligible for it.

Whether these patients would request MAID themselves is a different story. Though Emanuel, Fairclough, and Emanuel (2000) found that the majority, or 60.2%, of the dying patients that they surveyed expressed support for PAD and VAE “in a hypothetical situation,” most did not want it for themselves. Moreover, half of those that stated that they supported PAD and VAE expressed a change of opinion in a follow-up interview that occurred two to six months later (pp. 2460-2461). Nevertheless, it appears that most patients would like others to have the option.

Tomlinson, Spector, Nurock, and Stott (2015) turn to the caregivers of patients and show similar support. They interviewed past caregivers of patients with dementia, albeit with a small sample size of sixteen (p. 720). While participants acknowledged the

risks PAD poses with dementia, some participants supported having this option and would potentially request it if they ever developed dementia themselves (p. 725). Furthermore, of the caregivers that Emanuel, Fairclough, and Emanuel (2000) also interviewed, 58.7% supported VAE when the patient experienced suffering, and 29.1% supported VAE and PAD when the patient felt like he or she was “a burden” (p. 2463). Scholars have shown that dying patients and their caregivers typically support PAD and VAE.

Reasons to Request MAID

Meanwhile, some scholars focus on patients’ reasoning behind requesting PAD (see Sullivan, Hedberg, & Fleming, 2000; Pearlman et al., 2005; Ganzini, Goy, & Dobscha, 2008; and Breitbart et al., 2000). The scholars cited in this literature review corroborate each other. Sullivan, Hedberg, and Fleming (2000) interviewed family members of patients who opted for PAD between 1998 and 1999 (p. 599). Sixty-three percent of these family members stated at least three justifications behind their loved one’s requests: “loss of control of bodily functions (68 percent), loss of autonomy (63 percent), [and] physical suffering (53 percent)” (p. 601). Ganzini, Goy, and Dobscha’s (2008) also interviewed family members of patients who opted for PAD, but in Oregon specifically, and cited the following similar justifications as being the most common: “[W]anting control of the circumstances of death; loss of dignity; wanting to die at home and concerns about loss of independence, quality of life, ability to care for self in the future” (p. 154).

There are many studies that give these same reasons—even ones that interview the patients themselves. Pearlman et al. (2005) interviewed both the patients who opted

for PAD *and* their family members between 1997 and 2001 (p. 234). They, like Sullivan et al. (2000) and Ganzini et al. (2008), found that requests were often justified due to the symptoms of illness, a need for self-control, and anxiety regarding the future, which often included fears of pain (Pearlman et al., 2005, pp. 328, 327). Breitbart et al. (2000) conducted a survey of cancer patients and conclude that two factors were usually attributable to those patients that desired a hastened death: “Depression and hopelessness are the strongest predictors of desire for hastened death” (p. 2907).

Reasons NOT to Request MAID

One of the biggest indicators as to whether an individual supports or opposes PAD is their religious affiliation or lack thereof (see Burdette, Hill, & Moulton, 2005 and Hamil-Luker & Smith, 1998). Using a General Social Survey from 1998, Burdette, Hill and Moulton (2005) conclude that Catholics and Protestants oppose PAD more often than people who are not religiously affiliated (pp. 79, 90). This is especially true for those that attend church regularly (p. 90). Likewise, Hamil-Luker and Smith (1998) conclude that “the odds of the nonreligious approving [PAD] are three times greater than the religious” (p. 373). They found that the non-religiously affiliated supported PAD the most, at 90%, and evangelical Protestants supported PAD the least, at 42.4% (p. 382). Clearly, the general population, notably patients and their caregivers, has been thoroughly studied for their views on PAD.

The Medical Community

The medical community has been thoroughly studied as well. In fact, health care practitioners often write their own articles that state their views. Consider two well-known physicians and their works: Quill (1994) who obviously supports PAD and Orr

(2001) who obviously does not. This subsection will explore the literature on the debate of the permissibility of MAID from the perspectives of those that provide it. This subsection will also explore the literature on the fields of end-of-life care and nursing specifically.

General Opposition

Curry, Schwartz, Gruman, and Blank (2000) conducted a survey of 909 physicians to determine their views on PAD (p. 337). Nineteen percent of respondents were convinced that proper end-of-life care would prevent requests for PAS and that this care needs to be improved (Curry et al., 2000, pp. 343, 345). Sixteen percent expressed concern for depression (p. 346). Fourteen percent discussed how PAD is contrary to professional ethics (pp. 347-348). Eleven percent expressed concern for PAD leading to a slippery slope, citing the vulnerable and Nazism (p. 349). Six percent overtly opposed PAD on moral grounds (p. 351). Clearly, Orr (2001) is not the only physician to oppose PAD.

However, Curry et al. (2000) also found that “[t]en percent of all physicians answering the open-ended question expressed support of PAS in specific cases” (p. 352). These cases include those that satisfy “patient-based criteria,” which refers to whether the patient has such quality of life, or rather lack thereof, to be a candidate for PAD; “physician-based criteria,” which refers to whether the physician is competent in end-of-life and PAD care; and “provision of procedural safeguards[,]” which refers to the role of the psychiatrist in further evaluating the patient (pp. 352-353). Furthermore, Curry et al. found that few physicians mentioned the principle of autonomy when discussing PAD, with this aspect being “raised in 7% of [their] comments.” They also found that few

physicians defined PAD as a compassionate act, with only 3% of their comments alluding to this definition (p. 354). The literature reviewed thus far has shown that physicians are not strongly supportive of PAD, especially when compared to patients.

Not surprisingly, then, a more narrow study of psychiatrists specifically showed lack of support as well. In their comparative study of forty-nine psychiatrists and fifty-four physicians from Israel; Levy, Azar, Huberfeld, Siegel, and Strous (2013) found that psychiatrists were less likely to support euthanasia than physicians (pp. 402, 405). It must be stressed, however, that this study is based on the Middle East. The one weakness from this article, then, as it concerns this thesis' scope, is that other studies cited, such as one from Washington, show that the inverse is true in North America (p. 405). Erlbaum-Zur (2006) turns us to the views of social workers. She used a survey of 312 social workers from "not-for-profit long-term care facilities across New York" (pp. 175-176). She finds that almost half of these social workers support the legalization of PAD compared to the 20% who "believe that PAS is never ethical" (p. 184). These scholars show that different experiences of different professions yield different views on MAID.

These views are not only practiced, but they are also often published. Siu (2010) examines how British and American medical journals, among other publications, covered Jack Kevorkian (p. 169). The American Medical Association (AMA)-owned *Journal of the American Medical Association*, for example, portrayed Kevorkian both negatively, as using methods akin to Nazis, and positively, as a physician of compassion (pp. 174, 185). Nevertheless, this journal was able to trigger "moral shock in the American medical community" by covering Kevorkian "as twisting the interpretation of the Hippocratic oath" (p. 185). More broadly, American medical journals tend to highlight the potential

for a slippery slope. And although the AMA overtly opposes PAD in this journal, it acknowledges the weaknesses of end-of-life care in various articles (p. 186).

End-of-Life Care

Scholars debate PAD and VAE's effects on end-of-life care. Orr (2001) recalls a past patient who requested PAD. Anna suffered from breast cancer that metastasized to her bones, and she wanted "one big dose of morphine to get rid of the pain forever" (p. 131). Anna passed away since, but Orr did not assist her in doing so. Orr does not state that he feels guilty for his lack of assistance; rather, he states that he feels guilty that his "inexperience and incompetence" as a young physician may have "led to that desperate request" (p. 131).

Orr (2001) notes the importance of end-of-life care, notably pain relief, to avoid such requests. In fact, he deems proper care a "morally, legally, and professionally acceptable alternative" to PAD and VAE (p. 131). Citing Hippocrates and the AMA, Orr argues that assisting in death is incompatible with being a physician (p. 132). Orr offers his solution of "whole-person care[,] wherein experts from various fields satisfy all of the dying patient's needs, from treating his or her depression to helping with his or her relationships (pp. 134-135). Orr also acknowledges that physicians have not been relieving pain sufficiently, but he also acknowledges that physicians have the resources to do so and thus prevent PAD requests (p. 135).

Foley and Henden (as cited in Malakoff, 2006) point to the mutual exclusivity of PAD and this type of care. On one hand, they note that this debate has led to an increased focus on improving end-of-life care. On the other hand, they worry that PAD may lead to patients avoiding such care altogether (p. 41). Perhaps this is why, according to the

Canadian Society of Palliative Care Physicians (as cited in Eggerston, 2015) announced that most palliative care physicians do not want to provide MAID and do not see it as part of end-of-life care (p. E177).

Gill (2009) finds the argument that end-of-life care is incompatible with PAD is flawed (p. 27). Gill (2009) begins with the premise that even those with sufficient end-of-life care may request PAD, estimating that at least 12% of dying patients with such care are interested in the option (p. 28). And though he finds conflicting studies on whether depression is correlated with PAD requests, he is confident that those who are depressed will not be eligible for PAD in the first place (pp. 29-30). There are, nevertheless, some psychological conditions, like hopelessness, that are expected with some physical conditions and unable to be relieved with end-of-life care (pp. 34-37). He concludes that PAD can be accommodated in, and even complement, end-of-life care (pp. 38-39).

Nursing

Nurses and nurse practitioners play fundamental roles in PAD, VAE, and MAID. Saunders (2001) argues that though “the legal role of the nurse is often unclear” in jurisdictions around the world, their participation can be active (p. 79). Even if a nurse cannot provide the means to achieve death, Saunders explains, he or she can be active by advocating for the patient’s needs and educating the patient on his or her choices (pp. 79-80). As one will see, the roles and responsibilities of nurses and nurse practitioners vary by jurisdiction. In order to get an idea of their roles and responsibilities in cases of PAD and VAE without crossing too many jurisdictions, the next set of scholars discussed focus on nurses in Flanders, Belgium.

While physicians are the only individuals legally able to provide VAE in Belgium, the next scholars discussed all acknowledge the role of nurses in these cases (Schuklenk et al., 2011, p. 79). Based on interviews with eighteen nurses, Denier, Gastmans, De Bal, and Dierckx de Casterlé (2010) found that nurses perceive communication as key in cases of VAE (pp. 3374, 3378). Communication, they found, takes many forms, including “*active listening*” and “*providing information*”; and has many purposes, including ensuring patients are making suitable choices and defending these choices (pp. 3374-3376). Inghelbrecht, Bilsen, Mortier, and Deliens (2010) interviewed nurses as well and found that nurses often participate in euthanasia more fully than they are legally allowed to do (p. 905). Bilsen, Vander Stichele, Mortier, and Deliens (2004) interviewed physicians and found similar results (p. 583). Accordingly, they found that nurses provided lethal drugs in 59% of the VAE cases that took place in institutions (pp. 586-587). While most of the literature discussed in the other parts of this chapter refer specifically to physicians, it is reasonable to conclude that more attention is owed to nurses.

This is especially true since the passing of Bill C-14, or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (2016), in Canada, which allows nurse practitioners to provide MAID (s. 3). Sangster-Gormley (2016) defines nurse practitioners as “registered nurses with additional education, usually a master’s degree, who may order and interpret diagnostic tests, communicate a diagnosis to patients[,] and prescribe medications” (p. 173). This position was first introduced in the US (DiCenso et al., 2007, p. 105). Guido (2004) explains that nurse practitioners emerged in response to the lack of physicians in some areas in the

1960s (p. 608). This position then emerged in Canada, with Dalhousie University being the first university to create a program that would train nurse practitioners to work in northern Canada's more isolated areas in 1967 (DiCenso et al., 2007, p. 105). The role of the nurse practitioner has expanded ever since.

This expansion is evident internationally. To limit scope, this literature review will focus on North America, predominantly on Canada. In an article based on the US, Guido (2004) describes nurse practitioners' roles as "evolving" (p. 608). Guido explains that the first set of nurse practitioners worked in primary care, and since then, they have expanded into acute care (p. 608). In Canada, DiCenso et al. (2007) describes nurse practitioners' "expanded role" as being made possible by provincial and territorial legislation (p. 105). At the time DiCenso et al. wrote this article, the Government of Yukon was the only government without legislation (Canadian Nurses Association and Canadian Institute for Health Information, as cited in DiCenso et al., 2007, p. 105). And since then, in 2012, nurse practitioners have been regulated in the Yukon (Government of Yukon, 2014, para. 5). Thus, the roles and responsibilities of the nurse practitioner is recognized and regulated in Canada.

And though these roles and responsibilities vary by province, their expansion is seen throughout Canada. Sangster-Gormley (2016) gives an example of the expansion of nurse practitioners' roles in Ontario specifically. Before 2011, nurse practitioners could only prescribe specific drugs and often only renewed prescriptions that were initially provided by a physician. In 2011, the drugs that nurse practitioners can prescribe expanded to include "controlled drugs and substances" (p. 173). Moulton (2002) gives another example. She discusses proposed legislation in New Brunswick that would

expand nurse practitioners' roles to include tasks they did not have before, including diagnosing common conditions and prescribing certain drugs (p. 391).

Nowhere is the expansion of nurse practitioners' roles more evident than in Bill C-14. This new role is significant for various reasons. First, this bill, which is now a law, makes Canada the first country internationally that explicitly allows nurse practitioners to assist in death (Stokes, 2017, p. 151). Second, by including nurse practitioners, this law uses the term MAID. St-Denis (2016) explains that this is important because invoking the term PAD over MAID may have resulted in barriers for those many Canadians who live in rural areas (p. 11). Third, provincial variances in the roles and responsibilities of nurse practitioners will impact whether a nurse practitioner could *or* should provide MAID. For example, when the *New Classes of Practitioners Regulations* was passed and nurse practitioners were given federal approval to prescribe a new class of drugs, nurse practitioners' abilities to prescribe these drugs depended on "existing legislation and scope of practice in a jurisdiction" (PERSPECTIVES, 2013, p. 7). Nevertheless, the potential expansion of nurse practitioners' roles in to this terrain will hopefully precipitate more literature on their roles in assisting death and VAE.

Social Movement Organizations (SMOs)

The literature has, thus, shown that while patients generally support MAID, physicians generally do not. The literature has also shown that MAID has a specific impact on end-of-life care and nurse practitioners. This subsection will focus on groups that are based on the support and opposition of PAD and VAE.

Pro-PAD and VAE Movement

In addition to examining medical journals, Siu (2010) also examines SMOs' publications. More specifically, Siu compares "*Timelines*, the quarterly publication of the Hemlock Society...[and] the *IAETF Update*, the International Anti-Euthanasia Task Force's [(IAETF)] bi-monthly newsletter" when it comes to their "coverage of Kevorkian" (p. 173). The Hemlock Society is an SMO that supports the legalization of PAD, and the IAETF is a taskforce that staunchly opposes it (p. 174). Especially when considering that the former organization raised money for Kevorkian's legal expenses, it is not surprising that *Timelines* portrayed him positively (p. 187). The *IAETF Update*, on the other hand, criticized Michigan for not convicting him sooner. In the words of Siu, the former publication portrayed him "as a humanitarian, crusader, and tragic hero" and the latter portrayed him "as stupid, sinister, a Dr. Death" (p. 188). While Siu examines specific publications, another scholar surveys the history of the pro-PAD movement (see McInerney, 2000).

McInerney (2000) surveys developments that helped weaken or advance what she calls "the requested death movement" (p. 137). This includes historical developments. For example, while the Holocaust spurred negative connotations of euthanasia, advancements in medicine in the later half of the century presented the problem of protracted deaths and spurred support for PAD (pp. 140-141). McInerney also notes the developments of so-called 'lone proponents,' most notably Kevorkian (p. 141). His political efforts included sending a video of himself assisting in a death to CBS, which later aired it on *60 minutes* in 1998, and embarking on a hunger strike once he was convicted in 1999 (p. 142). McInerney also notes the efforts of the overall movement. For example, SMOs use 'victims,' such as Rodriguez, and events, such as mercy killings that

end in prosecutions, to garner sympathy; and public opinion polls, including their own, to keep PAD on the policy agenda (pp. 143-145). McInerney focuses on the pro-PAD movement.

Meanwhile, others criticize it (see Callahan, 2008; Amundson & Taira, 2005; and Coleman, 2010). Callahan (2008), for example, argues that numerous proponents of PAD rely on “organized obfuscation as a political tactic” (pp. 30-31). Callahan criticizes Oregon and Washington’s use of the saying ‘death with dignity’ in their PAD laws. Its use, he argues, implies that suicide is the only dignified death. In fact, proponents purposefully avoid the word ‘suicide’ because they know it might turn voters off (p. 31). Callahan also predicts that voters believe PAD laws are aimed at relieving intolerable pain, but that is not a requirement in Oregon. And lastly, Callahan argues that Oregon does not provide the public with important information and predicts that Washington will do the same (p. 32). The next set of scholars to be discussed examines the pro-PAD movement from a different angle: that of the disability rights movement.

Disability Rights Movement

Amundson and Taira (2005) supported PAD but now oppose it as a result of changes in their lives (p. 53). After becoming wheelchair-bound in 1992 due to Post-Polio Syndrome, Amundson realized that having a disability is not the problem, ableism is. It “falsely treats impairments as inherently and naturally horrible” (p. 54). He rejects the pro-PAD movement because proponents often refer to disability, not pain, as a reasonable justification to request PAD (p. 54). After suffering brain damage from a car accident in 1992 and overhearing a healthcare worker state that she would commit suicide if she were Taira, Taira realized the potential for abuse even from those in charge

of helping her (pp. 55-56). Amundson and Taira conclude with statistics that show pain is often not a justification for seeking PAD, leading them to ask the question: “[H]ow could anyone maintain their self-respect and dignity and still be willing to live with a disability?” (p. 56).

Coleman (2010) would agree with the above scholars (p. 39). Instead of relying on personal experiences, Coleman examines the amicus briefs of Not Dead Yet and Autonomy, Inc. in *Baxter v. State of Montana* in 2009 (p. 40). Not Dead Yet is a “disability rights organization” that opposes PAD, and Autonomy, Inc. also advocates for disability rights but supports PAD (p. 39). Coleman supports Not Dead Yet’s arguments and responds to Autonomy, Inc.’s rebuttals (p. 40). Coleman (2010) argues, among other things, that the common justifications for PAD wrongly depict those with disabilities as non-autonomous and lacking dignity (pp. 41-42).

Behaniuk (2011) thinks the problem is rooted in the way that the term ‘dignity’ is used. She argues that PAD proponents, such as Compassion & Choices, and opponents, such as Not Dead Yet, have different conceptualizations of what ‘dignity’ is and are, in fact, more similar than not (pp. 18, 17). There is, unfortunately, not much literature with the same optimism for the opportunity of convergence that Behaniuk depicts. In fact, all of the literature reviewed, whether from an ethical, legal, or political perspective, has shown a lack of neutrality concerning PAD and VAE.

Gaps in the Literature

Due to the contention surrounding PAD, VAE, and MAID, it is not surprising that ample literature exists. However, there are still gaps that should be addressed. As seen in

this literature review, literature on PAD, VAE, and MAID focuses mainly on the US and Europe. Since Bill C-14 is Canada's first successful bill to regulate MAID and was passed about one year ago, literature on these topics from a Canadian perspective is—not surprisingly—lacking. Furthermore, literature on these topics usually focuses on the roles of physicians. As discussed, nurses and nurse practitioners also play fundamental roles in these acts. And since Canada is the first country in the world to legally allow nurse practitioners to assist in death, literature on nurses' direct involvement is needed now more than ever (Stokes, 2017, p. 151). And lastly, since a free vote took place on Bill C-14, this topic presents an opportunity for additional literature on party discipline (Wherry, 2016, para. 2). Literature exists on other instances where free votes were held on moral issues (see Plumb, 2013 and Overby, Raymond, & Taydas, 2011), but due to the relatively recent passing of this law, more literature is needed on Bill C-14 specifically. This thesis contributes to the literature by analyzing the debates of a recently enacted law that gives new roles to nurse practitioners and whose voting records provide insight on free votes.

CHAPTER 3

METHODOLOGY

As captured by Chapter 2, physician-assisted death (PAD), voluntary active euthanasia (VAE), and medical assistance in dying (MAID) are highly contentious topics. It, therefore, follows that legislation regulating them would be contentious. MAID is new to Canada, and thus, literature on these topics is seldom discussed from a Canadian perspective. This thesis attempts to fill this gap.

Objectives

My overall objective is to identify key areas of concern as Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, made its way through the Parliament of Canada.

Research Questions

My research questions are as follows:

1. What were the major issues that dominated the debates in the House of Commons and the Senate regarding Bill C-14?
2. And on what grounds did Members of Parliament (MPs) and Senators support or oppose Bill C-14?

The first research question inevitably consists of a discussion on the second research question. It is important to note that while there are some actors that are staunchly opposed to or supportive of MAID, opponents and supporters alike recognize the supremacy of the Supreme Court of Canada (SCC) ruling and the importance of legislating it. And due to the exploratory nature of these research questions and the

resulting inductive approach I adopted in my research, this thesis does not test a hypothesis per se. Archer and Berdahl (2011) define the *inductive* approach as “observing the world and from our observations develop generalizations and conclusions” (p. 35). All in all, answering these research questions will provide important insight on MAID in Canada and perhaps lead to specific hypotheses that can be tested in the future.

Sources

My data consists of two primary sources: Bill C-14 itself and Hansard. I found these sources through the Parliament of Canada’s website, specifically through *LEGISInfo*, which “is a collaborative effort of the Senate, the House of Commons and the Library of Parliament” (*LEGISInfo*, n.d., Introduction).

Bill C-14

I examined multiple versions of Bill C-14 in order to understand the parliamentary debates. I also typically referred to and used excerpts of the final version of Bill C-14 as I described my findings in Chapter 4. There are four published versions of Bill C-14: as it was introduced to the House of Commons, as amended by the Standing Committee on Justice and Human Rights (JUST), “[a]s passed by the House of Commons[,]” and as it received Royal Assent (*LEGISInfo*, n.d., House government bill C-14 (42-1)). As previously noted, I examined all of them to thoroughly understand the debates. This was especially helpful for my third theme, whereby a major change in the legislation occurred when JUST amended it, appealing to both opponents and supporters of MAID alike. These kinds of changes are discussed when needed and in more detail in Chapter 4.

Hansard on Bill C-14

Second, I examined Hansard on Bill C-14. This includes parliamentary debates from both the House of Commons and the Senate. Bill C-14 was introduced to the House of Commons on April 14, 2016, and its first debate or second reading began on April 22, 2016. Excluding the committee stages, Bill C-14 was discussed extensively on nine days in the House of Commons and nine days in the Senate. Bill C-14 received Royal Assent on June 17, 2016 (LEGISinfo, n.d., House government bill C-14 (42-1)). I examined the Hansard concerning Bill C-14 as it achieved each stage and eventually became a law. To supplement the Hansard, I also examined the record of votes and journals.

Methods

The approach used is often called *thematic analysis*. Clarke and Braun (2017) offer a definition: “Thematic analysis (TA) is a method for identifying, analyzing, and interpreting patterns of meaning (‘themes’) within qualitative data” (p. 297). I chose this method because of the highly qualitative nature of my sources and the flexibility that thematic analysis offers. In other words, identifying ‘themes’ made sense for a topic that has multiple ethical, legal, and political dimensions. Since there are so many areas of concern in this highly contentious topic, it followed that identifying “patterns within and across data” was simply the only tangible way of presenting research (p. 297).

First, I became acquainted with the issues concerning Bill C-14. Not only did I skim the debates initially, I also read other sources to familiarize myself with the issues, including newspaper articles that were published when Bill C-14 was being debated. This also included reports and briefs submitted to various committees on the issue.

Committees included the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group) (AG), the Special Joint Committee on Physician-Assisted Death (PDAM), JUST, and the Standing Senate Committee on Legal and Constitutional Affairs (LCJC).

Second, I read my main sources thoroughly. It is important to note that, with this step, I was guided by the phases of thematic analysis explained by Braun and Clarke (2006, pp. 87-93). As I read the Hansard on Bill C-14, I manually created *codes*. Clarke and Braun (2017) define codes as “the smallest units of analysis that capture interesting features of the data” (297). More specifically, I read the sources carefully, highlighted and made notes on key topics, and brainstormed codes that corresponded to these key topics. In the end, I had an array of codes on many topics. I then sorted these codes into broad themes and sub-themes. And once I finalized my potential themes and sub-themes, I re-read the Hansard on Bill C-14 and put excerpts of data into each theme.

Third, after meticulously refining and analyzing my themes and sub-themes, I wrote my findings, which can be found in Chapter 4. As one will see, I start each theme with related excerpts from Bill C-14. Following commentary from those MPs and Senators that support the bill, I then provide commentary from those MPs and Senators that do not support the bill. In the end, one will find a concise narrative on the major issues that dominated the debates and the grounds on which Bill C-14 was supported or opposed. Table 4 below briefly summarizes my themes and sub-themes.

Table 4
Brief Summary of Themes and Sub-Themes

Theme	Sub-Themes or Key Topics	Relevant Section of Bill C-14 <i>Criminal Code</i>	
Constitutionality	Eligibility criteria, namely	S. 3	S. 241.2

	that the patient’s condition be “incurable” and his or her death be “reasonably foreseeable”		(2) (a) and s. 241.2 (2) (d)
Ensuring Consent	Procedural Safeguards	S. 3	S. 241.2
	Independent Reviews, namely of mature minors, advance requests, and patients whose sole condition is mental illness	S. 9.1	N/A
Ensuring Access	Before Amendments	Preamble*	N/A
	Subsequent Amendments	Preamble and S. 3	S. 241.2 (9)

Note: Refer to An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), 2016.

*Refer to Bill C-14 (2016a).

CHAPTER 4

FINDINGS

Carter v. Canada (Attorney General)

As briefly discussed in Chapter 1, the judgment of *Carter v. Canada (Attorney General)* (2015) held that prohibiting physician-assisted death (PAD) violates section 7 of the *Canadian Charter of Rights and Freedoms*:

“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” (para. 147).

The *Charter* (1982) states, “Everyone has the right to life, liberty and security of the person” (s. 7). According to the Supreme Court of Canada (SCC) judgment, a blanket prohibition of aiding suicide results in even those Canadians who meet the above criteria being deprived of their right to life. More specifically, a prohibition may influence some individuals to seek premature death due to the fear of not being able to do so themselves in the future (*Carter v. Canada (Attorney General)*, 2015, para. 57). In addition, the SCC holds that a prohibition infringes eligible Canadians’ rights to liberty and security of the person (para. 64-65). The way in which individuals respond to suffering is “critical to their dignity and autonomy.” A prohibition results in individuals being able to request voluntary stopping of eating and drinking (VSED), for example, but being unable to

request PAD. By influencing these decisions, their liberty is impacted. But by leaving them to suffer, their security of the person is also impacted (para. 66). In the words of the SCC, “The choice is cruel” (para. 1).

The *Charter* (1982) also states that Canadians must not be deprived of these rights “except in accordance with the principles of fundamental justice” (s. 7). Based on recent and relevant jurisprudence, the SCC identifies three principles of fundamental justice (*Carter v. Canada (Attorney General)*, 2015, para. 72). First, the SCC acknowledges that since the objective behind prohibiting PAD is the protection of the vulnerable and prohibiting PAD does this, “individuals’ rights are not limited arbitrarily” (para. 84). The next two principles applied, however, focus less on the rights of society and more on the rights of individuals (para. 85, 89).

The SCC applied the principles of overbreadth and gross disproportionality (*Carter v. Canada (Attorney General)*, 2015, para. 72). The principle of overbreadth determines whether a law that denies individuals’ rights to support the objective *also* denies others’ rights with no relation to or effect on said objective (para. 85). Though Canada recognized that not every individual who seeks death is vulnerable, Canada still asserted on the *possible* vulnerability of *all* individuals. The SCC disagreed with this assertion and decided that a prohibition is, thus, overbroad (para. 86-88). The SCC then applied the principle of gross disproportionality. The SCC agreed with the trial judge that the prohibition severely impacts the life, liberty and security rights of the person. Though it is known that this impact is severe, it is also acknowledged that the objective of the protection of the vulnerable is important. Nevertheless, the SCC concludes that “it [is] unnecessary to decide whether the prohibition also violates the principle against gross

disproportionality” since it has already been decided that the prohibition is overbroad (para. 90).

Role of the Legislatures

Based on this interpretation of the *Charter*, the SCC ruled on February 6, 2015 that the prohibition of PAD is unconstitutional. The SCC stated, “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 (Attorney General)*, 2015, para. 126). In other words, the legislatures *may* pass laws regulating PAD, but these laws must not contravene the ruling. And if they choose not to pass laws, the prohibition of PAD is still void. The SCC did, however, suspend the decision for a year—presumably to give time for the legislatures to pass legislation in response (para. 128). In addition to this time, when the federal government sought a six-month extension in January 2016, the SCC granted a four-month extension (Fekete, 2016, para. 2, 1). Ultimately, whether the federal government passed legislation concerning PAD or not, PAD became a right for eligible Canadians as a result of the *Carter v. Canada (Attorney General)* ruling and enshrined in the *Charter* on June 6, 2016.

There were various efforts leading up to this date. In April 2015, former Minister of Justice the Honourable Peter MacKay (CPC) noted the sensitivity of the issue and stated that the federal government would not introduce legislation on PAD before the election in October (Blanchfield & Bryden, 2015, para. 7, 1). A few months later, the federal government created the External Panel on Options for a Legislative Response to *Carter v. Canada* in July (Government of Canada, 2016). Meanwhile, the provinces and territories, directed by Ontario, created the Provincial-Territorial Expert Advisory Group

on Physician-Assisted Dying (Advisory Group) (AG) in August (Ministry of Health and Long-Term Care, 2015, para. 3). The External Panel and the AG were created to provide expertise to their respective level of governments on how to draft legislation in response to the ruling (para. 4; Government of Canada, 2016). With the election over and a new government in power, the Special Joint Committee on Physician-Assisted Death (PDAM) was created to address the issue of PAD.

Consisting of both MPs and Senators, the PDAM was created specifically to analyze the work of the External Panel, discuss PAD and other related topics with organizations and individuals, and provide legislative recommendations on how to mandate PAD (Special Joint Committee on Physician-Assisted Dying, 2015). The committee submitted their report, which consists of twenty-one recommendations, in February 2016 (Special Joint Committee on Physician-Assisted Dying, 2016a). It is multi-partisan, including six Liberal Party of Canada (LPC) MPs, three Conservative Party of Canada (CPC) MPs, and two New Democratic Party of Canada (NDP) MPs at the time that they submitted their final report. However, the four CPC MPs who had served on the committee submitted an alternative report that sought more safeguards (Special Joint Committee on Physician-Assisted Dying, 2016b). Both reports were submitted with hope of influencing the highly anticipated bill that would mandate PAD.

Bill C-14

Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, was introduced on April 14, 2016 and became law on June 17, 2016. Minister of Justice the Honourable Jody Wilson-Raybould (LPC)

sponsored the bill (LEGISinfo, n.d., House government bill C-14 (42-1)). During its second reading, she described the bill as the following: “It respects personal autonomy, protects the vulnerable, and affirms the inherent value in every human life” (Wilson-Raybould, 2016, April 22). And as one will see, the biggest challenge in drafting medical assistance in dying (MAID) legislation that would gain support of Parliament was striking a balance of these three values. It must be noted that this challenge was precipitated by a free vote. Though the LPC held a majority government and bills introduced by majority governments are typically passed with ease, MPs were free to decide for themselves if Bill C-14 struck the right balance (Wherry, 2016, para. 2).

Basic Information

Before examining the Hansard and various issues that MPs and Senators debated, it is important to know basic information about the bill that is now a law. Fundamentally, it amends the *Criminal Code* to allow MAID (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, ss. 1-6). It amends s. 14, adds s. 227, and amends s. 241 to allow physicians and nurse practitioners to legally provide MAID (ss. 1-3). It amends s. 241 to create exemptions for anyone else that might be involved, including pharmacists who provide lethal prescriptions. It also amends s. 241 to include criteria that individuals must meet to receive MAID and the procedural safeguards that must be met in fulfilling these requests (s. 3). Sections are also added to s. 241 that pertain to recordkeeping and reporting of MAID requests and cases (s. 4).

The law under study goes beyond amending the *Criminal Code*. It also amends other laws, including the *Pension Act* and the *Corrections and Conditional Release Act*,

in light of MAID becoming legal (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, ss. 7-8).

Furthermore, as captured by the Hansard and as will soon be analyzed, a controversial part of this legislation is s. 9.1(1-2). Here, it is required that independent studies be undertaken into “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” (s. 9). Lastly, in the next section, it is required that the law be reviewed by a committee five years after its passing (s. 10).

Parliamentary Debates

The bill took roughly two months to become a law (LEGISinfo, n.d., House government bill C-14 (42-1)). By knowing the ethical, legal, and political issues surrounding MAID encapsulated in Chapter 2, it should be no surprise that MPs and Senators offered a diverse array of opinions and passion on the topic in a short period of time. As previously noted, this diversity was further encouraged by a free vote (Wherry, 2016, para. 2). Many MPs and Senators contributed personal experiences. For example, during the second reading in the House of Commons, LPC MP Arnold Chan (2016, May 3) revealed his recurrent cancer diagnosis. During the third reading in the Senate, the Honourable Josée Verner (2016, June 9) revealed her recent cancer diagnosis. Meanwhile, many discussed their experiences with their loved ones dying. Expectedly, none of the MPs or Senators spoke lightly of the topic of MAID.

In addition to the personal significance of the topic, some MPs and Senators were motivated by the date of June 6—when the SCC extension was over. Some, like Minister of Health the Honourable Jane Philpott (2016, April 22) (LPC), stressed from the

beginning of the debates of the importance of having a law in place by this time. The term ‘legal vacuum’ was used fifteen times on the second day of the second reading. Others, like CPC MP Kelly Block (2016, May 31), suggested the use of the *Charter’s* notwithstanding clause, to override the SCC decision and thus provide more time for discussion. Meanwhile, others, like NDP MP Murray Rankin (2016, May 31), noted the medical association guidelines already in place to retort the fear of a ‘legal vacuum.’ He stated, “Let us take the time, I say, to get it right, not to get it done right now.” Many other MPs and Senators shared this sentiment.

While personal experiences and the discussion of a ‘legal vacuum’ or lack thereof were overarching and important themes throughout Bill C-14’s progression through both legislative chambers, the analysis that follows will discuss themes pertinent to the content of the bill itself. These themes include constitutionality, namely Bill C-14’s compliance or failure of compliance with *Carter v. Canada (Attorney General)*; ensuring consent, which consists of sub-themes, including procedural safeguards and independent studies; and ensuring access, referring to the rights of health care practitioners involved in administering MAID and the ability of those eligible and seeking MAID to get this service. These themes encapsulate the various issues MPs and Senators had with Bill C-14, thus showing the struggle between those who wanted to further restrict eligibility versus those who wanted to expand access.

Voting

Before analyzing the parliamentary debates, discussion is warranted on how MPs and Senators ultimately voted on Bill C-14. Refer to Table 5 and 6 below for a breakdown of voting in each chamber at the final stages. It is interesting to note that

while there is little difference between the number of MPs who supported Bill C-14 between third reading and just prior to its acquiring of Royal Assent, the number of Senators who supported Bill C-14 decreased by twenty between third reading and just prior to its acquiring of Royal Assent. This may be due to the House of Commons rejecting an amendment made by the Senate to remove a key component of the bill (Canada, Parliament, House of Commons, 2016d). This will be discussed in more detail in this chapter.

Table 5
Votes Details from the House of Commons

Date and Stage	Yeas	Nays
May 31, 2016 Third Reading	186	137
June 16, 2016 Prior to Royal Assent	190	108

Note: Data in table from Canada, Parliament, House of Commons, 2016b and Canada, Parliament, House of Commons, 2016c.

Table 6
Vote Details from the Senate

Date and Stage	Yeas	Nays
June 15, 2016 Third Reading	64	12
June 17, 2016 Prior to Royal Assent	44	28

Note: Data in table from Canada, Parliament, Senate, 2016f and Canada, Parliament, Senate, 2016g.

Furthermore, as previously noted, a free vote took place, thus decreasing the effect of party discipline (Wherry, 2016, para. 2). Nevertheless, a closer glance at the voting records still shows trends specific to each political party. Refer to Table 7 below. For example, while there are notable exceptions, most LPC MPs voted in favour of Bill C-14; most CPC MPs voted against Bill C-14; and all NDP, BQ, and GP MPs voted

against Bill C-14 (Canada, Parliament, House of Commons, 2016b, 2016c). These are trends that will be evident in the analysis of the parliamentary debates that follows.

Table 7
Vote Details from the House of Commons by Political Party

Date and Stage	Votes by LPC MPs		Votes by CPC MPs		Votes by NDP MPs		Votes by BQ and GP MPs	
	Yeas	Nays	Yeas	Nays	Yeas	Nays	Yeas	Nays
May 31, 2016 Third Reading	172	4	14	81	0	41	0	11
June 16, 2016 Prior to Royal Assent	168	3	22	58	0	40	0	7

Note: Data in table from Canada, Parliament, House of Commons, 2016b and Canada, Parliament, House of Commons, 2016c.

Theme 1: Constitutionality

Since Bill C-14 was a response to the *Carter v. Canada (Attorney General)* ruling, it is no surprise that MPs and Senators discussed its compliance, or lack thereof, with the ruling. Most of the discussion dealt with Bill C-14’s eligibility criteria and more specifically, its definition of a “grievous and irremediable medical condition[.]” From its introduction to its passing as a law, this definition did not change (Bill C-14, 2016a, 2016b, 2016c). S. 241.2 (2) of the *Criminal Code* states that one possesses this condition if they meet four requirements, two of the most contentious being paragraphs (a) and (d) that state the condition must be “serious and incurable” and “their natural death has become reasonably foreseeable” respectively (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). Please note that this discussion will mainly focus on these two requirements.

Minister of Justice Wilson-Raybould (2016, April 22) (LPC) stated that health care practitioners must read all four requirements together to determine eligibility. While this set of criteria will provide “a workable standard” to ensure those who are eligible to receive MAID can receive it, Wilson-Raybould argued, it will also prevent premature death of those who are not eligible. She stated that the SCC’s ruling in *Carter v. Canada (Attorney General)* only pertained to “factual circumstances” of the case (*Carter v. Canada (Attorney General)*, 2015, para. 127 as cited in Wilson-Raybould, 2016, April 22). And since the plaintiffs of this case would be eligible, she concluded that Bill C-14 directly responded to the ruling and was therefore *Charter*-compliant (Wilson-Raybould, 2016, April 22). While some MPs agreed, some MPs and Senators thought that the eligibility criteria should have been more restrictive and some thought the eligibility criteria was already too restrictive.

In response to both competing perspectives, Wilson-Raybould (2016, May 31) (LPC) reminded MPs that it was not a matter of simply copying the SCC ruling into a bill. The SCC, she added, required that Parliament not only respect the ruling but also “promote autonomy, protect the vulnerable, [and] affirm life,” among other tasks. In other words, the SCC should “provide the general parameters” and Parliament should “craft the regime.” In response to those who argued that legislation could not go “outside of the parameters of the [SCC] decision” without being unconstitutional, the Honourable Senator George Baker (2016, June 2) referred to *R v. Mills*, a sexual assault trial, as an example of a case where the SCC ruled that Parliament could create a legislative framework that contrasts with what the judiciary imagined and still be considered

constitutional. Likewise, LPC MPs typically spoke of the framework as allowing access to eligible individuals but also restricting access enough to protect the vulnerable.

First, LPC MPs defended Bill C-14 on grounds that it respects the *Carter v. Canada (Attorney General)* ruling. Like Wilson-Raybould, LPC MP Sean Casey (2016, May 2) pointed out that, considering all of the four requirements, plaintiffs Kay Carter and Gloria Taylor would be eligible. Furthermore, the SCC did not define “grievous and irremediable condition.” Bill C-14, he argued, not only complies with the ruling, then, but it also “provides necessary clarity on the assessment of eligibility.” Other LPC MPs, including Anthony Housefather (2016, May 17) and Kate Young (2016, May 3), agreed that Bill C-14 complied with the SCC ruling.

Second, LPC MPs defended Bill C-14 on grounds that it restricts eligibility in ways that would protect the vulnerable *within* the parameters of the ruling. Arif Virani (2016, May 2) stated that the SCC ruling not only “required access to medical assistance to dying[.]” this access was also “subject to certain safeguards.” Wilson-Raybould (2016, May 31) claimed that, as heard by the Standing Committee on Justice and Human Rights (JUST) and Standing Senate Committee on Legal and Constitutional Affairs (LCJC), restricting eligibility to those who are dying significantly prevents risk. Vance Badawey (2016, May 3) also mentioned that if the government did not restrict eligibility in this way, it might reinforce harmful stereotypes about people with disabilities and promote premature death. More discussion on safeguards will follow in the next section.

Casey (2016, May 2), more specifically, discussed the ‘reasonably foreseeable death’ requirement. Acknowledging that death is inevitable for everyone, he stressed the words “has become” in the bill that require a change in one’s health. He explained that

health care practitioners would assess patients individually, or on “case-by-case basis[.]” to determine if this change will result in death. For example, Wilson-Raybould (2016, April 22) explains that though Carter suffered from spinal stenosis that would not directly cause her death, a combination of other factors, including her frailty, with this condition would eventually threaten her life. Ultimately, LPC MPs stressed the importance of health care practitioners using their knowledge and training to assess individual circumstances.

Third, LPC MPs defended Bill C-14 on grounds that experts support it even in spite of those legal experts who do not. Wilson-Raybould (2016, May 31) assured the House of Commons that the bill was constitutional, emphasizing her positions as both the Attorney General and Minister of Justice. Housefather (2016, May 17) acknowledged the competing perspectives by legal experts at JUST meetings, concluding that just about any bill “could be found unconstitutional[.]” Even CPC MP Gérard Deltell (2016, May 31) acknowledged that it is impossible to pass a bill that will not be challenged. And lastly, LPC MP Casey (2016, May 17) argued that while legal experts will debate Bill C-14’s compliance with the ruling, it is important to consider that organizations that represent health care practitioners, including the Canadian Medical Association (CMA) and Canadian Nurses Association, supported the bill. Afterwards, he asked, “[H]ow can we as parliamentarians discount the views of medical practitioners?”

Though some CPC MPs, such as Deltell (2016, May 31) and Michael Cooper (2016, April 22), believed Bill C-14 was *Charter*-compliant, others were still uneasy about the ‘reasonably foreseeable death’ clause. Deltell (2016, May 31) stated that the clause “means both everything and nothing.” Similarly, Scott Reid (2016, April 22) and

Garnett Genuis (2016, May 2) refer to ambiguity of the clause. The Honourable Peter Kent (2016, May 2), on the other hand, appreciated this ambiguity in light of the uncertainties of prognoses. Still, Genuis (2016, May 2) argued that everyone's death is reasonably foreseeable and that the flexibility invoked by this bill is, thus, not ideal for health care practitioners. He sought to bring clarity to the bill by proposing an amendment that individuals seeking MAID required "imminent natural death" (Genuis, May 17). This amendment failed by 150 votes but still received support from most CPC MPs (Canada, Parliament, House of Commons, 2016a). It is clear, then, that CPC MPs regarded the eligibility criteria, particularly the 'reasonably foreseeable death' clause, as too flexible.

Meanwhile, NDP MPs, some LPC MPs, and Senators argued that the eligibility criteria were too restrictive. First, many MPs and Senators did not agree that an individual has to have a "serious and incurable illness, disease, or disability" to qualify for MAID (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). NDP MP Murray Rankin (2016, April 22) was particularly vocal. The SCC, he explained, did not state that the patient must be 'incurable.' In fact, it specifically stated that individuals would not be forced to "undergo treatments that they would object to in order to be eligible for assistance in dying." As LPC MP Robert Oliphant (2016, May 2) explained, "The disease may be curable, but that person has chosen a different path and that, under section 7, is their right." Likewise, René Arseneault (2016, May 2), another LPC MP, referring to the absence of this adjective in the ruling, claimed that Bill C-14 took "a rather restrictive approach." Even MPs of the LPC questioned the compliance of Bill C-14 with the ruling.

This observation was not limited to the House of Commons. Like the MPs above, the Honourable Senators James S. Cowan (2016, June 2), Serge Joyal (2016, June 2), and Mobina Jaffer (2016, June 2), among others, expressed concern over the requirement of an incurable condition. Cowan (June 2, 2016) feared that it would force individuals to undergo unacceptable treatments, which “goes very directly against the Supreme Court’s decision in *Carter*.” Cowan does not understand why the government did not comply with the exact wording of the SCC. Joyal (2016, June 2) expressed this same fear, adding, “That’s what I don’t like in that bill.” Jaffer (2016, June 2) described the requirements as being needlessly restrictive, noting “they do not meet the threshold set by the Supreme Court in *Carter*.”

Second, many MPs and Senators did not agree that an individual’s “natural death has become reasonably foreseeable” to qualify for MAID (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). In both chambers, parliamentarians referred to the clause as not only restrictive but also ambiguous. NDP MP Don Davies (2016, May 3) expressed the concern that many MPs and Senators had—that this clause presents an “additional requirement” not present in the SCC ruling. And like some of the CPC MPs mentioned previously, NDP MP Rankin (2016, April 22) called the requirement “hopelessly ambiguous.” Constitutional lawyer Joseph Arvay, as cited by Rankin, predicted that the bill would be challenged for this clause. In addition, NDP MP Alistair MacGregor (2016, May 2) stated that this clause “goes against what the *Carter* decision specified and it goes against what the special joint committee recommended.” This discontent was not limited to the NDP or the House of Commons.

Though LPC MPs tended to defend Bill C-14 as directly responding to the ruling, LPC MP Nathaniel Erskine-Smith (2016, May 2), among others, worried that even one of the plaintiffs of the ruling would not have been eligible. In fact, both Bloc Québécois (BQ) MP Luc Thériault (2016, May 17) and Green Party (GP) MP and Party Leader Elizabeth May (2016, May 17) were confident that Carter would not be. In fact, the Honourable Senator Richard Neufeld (2016, June 2) stated that Carter’s children did not think their mother would satisfy the criteria. In addition to its alleged lack of compliance with the ruling, some parliamentarians worried if health care practitioners would be able to recognize a ‘reasonably foreseeable death.’ Oliphant (2016, May 2), another LPC MP, noted that physicians are unaware of the term and would have trouble using it. Similarly, the Honourable Senator Judith Seidman (2016, June 2) used a quote from the Federation of Medical Regulatory Authorities of Canada to show that the clause is too ambiguous for health care practitioners “to confidently determine who is eligible[.]”

Amendments were proposed in both the House of Commons and the Senate to make the wording of Bill C-14 match the *Carter v. Canada (Attorney General)* ruling. Given the contention surrounding this clause and the many LPC MPs overtly against it, it might seem surprising that NDP MP Rankin’s proposed amendment to delete this criterion failed with 47 ‘yeas’ and 271 ‘nays.’ It is, however, also important to note that it was mostly LPC and CPC MPs who voted against it (Canada, Parliament, House of Commons, 2016a). Thus, those LPC MPs who disagreed with the clause were exceptional.

In the other chamber, the Honourable Senator Joyal’s (2016, June 8) amendment to remove the ‘reasonably foreseeable death’ clause and, in other words, make MAID

accessible to those who are not dying, was adopted with 41 ‘yeas’ and 30 ‘nays’ (Canada, Parliament, Senate, 2016d). However, right before Bill C-14 procured its Royal Assent, Wilson-Raybould (2016, June 2016) pointed out some of the risks in extending eligibility without adding safeguards. This led to a final lengthy debate on the issue, a vote, and the ‘reasonably foreseeable death’ clause appearing again in the final version of the bill (Bill C-14, 2016c).

Theme 2: Ensuring Consent

Procedural Safeguards

Ss. 241.2 (1) and (2) of the *Criminal Code* define who is eligible for MAID (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). S. 241.2 (3) lists safeguards health care practitioners must follow when assisting in death. Throughout its journey through the House of Commons, Bill C-14 was repeatedly defended by LPC MPs as being flexible enough to provide adequate access but restrictive enough to protect the vulnerable.

Wilson-Raybould (2016, April 22) (LPC) often referred to the highly contentious s. 241.2 (2) (d), or the requirement that “natural death has become reasonably foreseeable,” as being flexible enough that those “on a trajectory toward death in a wide range of circumstances” are able to access MAID (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). On the other hand, she ensured that eligibility criteria and procedural safeguards would prevent abuse (Wilson-Raybould, 2016, April 22). All MPs and Senators stressed the importance of protecting the “vulnerable,” and this meant ensuring their consent.

LPC MPs defended Bill C-14 as protecting the vulnerable on various grounds. Many referred to the procedural safeguards. LPC MP Virani (2016, May 2) listed these safeguards in response to those that thought the bill was too permissive. He referred to safeguards that are in the final law. This includes s. 241.2 (3) (c), which requires the signature of two independent witnesses, and s. 241.2 (5) (a), which requires that the witnesses cannot be financial recipients of the individual's death, of the *Criminal Code (An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). LPC MPs Matt DeCoursey (2016, May 2), Larry Bagnell (2016, May 2), and Badawey (2016, May 2) all describe and refer to these safeguards, among others, to explain why they support the bill. In fact, Bagnell (2016, May 2) admitted to voting against a previous PAD bill due to the prevalence of elder abuse, but he alleged that he was "convinced" by Bill C-14.

Some LPC MPs compared Bill C-14 to PAD legislation of other jurisdictions. LPC MP Casey (2016, May 2) defended Bill C-14 by claiming: "The proposed safeguards are generally consistent with and perhaps even a little stronger than the safeguards found in other medical assistance in dying regimes around the world." Similarly, LPC MP Nicola Di Iorio (2016, May 3), after describing these various regimes, stated that the government learned from other jurisdictions. Some LPC MPs referred to support of various groups that represent vulnerable persons. This includes Minister of Health Philpott (2016, May 31), who, on the last day of the third reading cited "an open letter from 36 organizations representing the vulnerable" that showed support for Bill C-14. Thus, LPC MPs listed various reasons as to why MPs should support Bill

C-14 for its protection of the vulnerable. Even NDP MP Rankin (2016, April 22) thought the bill did “a good job” of ensuring that no one could be “pressured in anyway.”

Some MPs and Senators, however, were not convinced and feared of the slippery slope described in Chapter 2. Those who expressed this fear were disproportionately CPC MPs. For example, Genuis (2016, May 2) was not convinced of the safeguards:

“Even its exceptions are full of holes: the written consent provision excludes those who cannot sign; the waiting period can be routinely waived; mental illness is not excluded; the requirement that death be reasonably foreseeable would exclude no one; and the requirement that two doctors sign off merely encourages doctor shopping.”

In fact, the Honourable Ed Fast (2016, May 2) believed that, based on experiences from other jurisdictions, no safeguards can ensure the prevention of unwanted consequences. Likewise, the Honourable Senator Tobias C. Enverga (2016, June 2) spoke of Bill C-14’s “lack of procedural safeguards” and used studies from the Netherlands and Belgium to show that, even with a reporting mechanism, there have been instances of PAD that have lacked consent. Thus, the reasons MPs and Senators were concerned about Bill C-14’s impact on the vulnerable were varied, and so were the methods to address them.

One the most commonly referred to methods in the House of Commons was advance legal review. CPC MP Genuis (2016, May 2) was a strong advocate of this type of system, whereby a request has to be validated via “a competent legal authority[,]” to ensure consent. Even LPC MP John McKay (2016, May 2) expressed his desire for the inclusion of a lawyer to determine eligibility. Genuis proposed an amendment that would require that the request be authorized “by a competent legal authority[,]” which was

supported by 69 MPs but failed due to the 253 MPs who opposed it (Canada, Parliament House of Commons, 2016a). Contrastingly, Rankin (2016, April 22) was staunchly opposed to this type of system from the beginning, claiming that it “would be an absolute barrier for many people[.]”

In the other chamber, Senators had some ideas of new safeguards of their own and proposed amendments to this effect. While varied, the Honourable Claude Carignan (2016, June 9) also claimed that “judicial authorization” was one of the best ways to protect the vulnerable and proposed a similar amendment. Carignan’s amendment failed (Canada, Parliament, Senate, 2016b). In addition and as a prelude to the next subsection, the Honourable Frances Lankin (2016, June 14) wanted to create an additional area that the federal government would have to study—that of people who are or might be vulnerable by nature of “social conditions or social determinants of health[.]” Lankin’s amendment also failed (Canada, Parliament, Senate, 2016e). Alas, while some MPs and Senators thought that Bill C-14 required more safeguards, others worried about the effect of these safeguards on individuals’ rights to MAID.

Independent Reviews

Whereas the previous section discussed the objective of ensuring consent to protect the vulnerable, this section will discuss the objective of extending eligibility to those who might be eligible to access MAID. From its introduction to the House of Commons to its procurement of Royal Assent, Bill C-14’s (2016a, 2016c) preamble always included a commitment to studying other situations that fell outside of the *Carter v. Canada (Attorney General)* ruling: “namely situations giving rise to requests by mature minors, advance requests and requests where mental illness is the sole underlying

medical condition[.]” More specifically, s. 9.1 (1) of *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (2016) states that the Minister of Justice and Minister of Health must implement at least one independent review of these issues within 180 days of its procurement of Royal Assent. S. 9.1. (2) states that they must also present the resulting reports to the House of Commons and the Senate within two years of starting each review.

Minister of Justice Wilson-Raybould (2016, April 22) (LPC) referred to this an “evidenced-based approach [that] will allow us to respect the autonomy and the [C]harter rights of Canadians while ensuring robust protections for vulnerable persons.” LPC MP Virani (2016, May 2) referred to these studies when responding to claims that Bill C-14 was not “broad enough.” He uses the phrase “for now” to explain that there are limits on who is eligible for MAID; and if these limits were to be extended, he adds, this extension must occur after “comprehensive study.” While some MPs and Senators saw this as a balanced and logical approach, some were adamantly against extending MAID to these groups whereas others believed eligibility should have been extended to these groups from the beginning.

Mature Minors

S. 241.2 (1) (b) of the *Criminal Code* states that, in order to eligible for MAID, one must be “at least 18 years of age and capable of making decisions with respect to their health” (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). Wilson-Raybould (2016, April 22) (LPC) stated that more evidence is needed, especially considering that MAID is irreversible and minors are vulnerable. Similarly, LPC MP Joyce Murray (2016, May 2)

stated that not enough information is available on mature minors, hence the “cautious approach.” NDP MP Davies (2016, May 3) agreed with this approach. It is clear that LPC MPs tried to appeal to both opponents and supporters of extending eligibility criteria by referring to these reviews.

Many MPs were happy that mature minors were not included. Filomena Tassi (2016, May 2), an LPC MP, spoke about her experience working with teenagers as a chaplain and her thankfulness that mature minors are not eligible. Deltell (2016, May 2), a CPC MP, thanked the government for restricting eligibility to adults. He saw “six years of detailed, painstaking work” leading up to Bill 52, *An Act respecting end-of-life care*, becoming a law when he worked for the National Assembly of Quebec. This PAD law does not include mature minors. Based on this lengthy experience and co-authoring the ‘Dissenting Report’ of the PDAM, he stated that it was “good” that the government defined eligibility this way. Another CPC MP, Karen Vecchio (2016, May 20), a mother of five children, supported the bill, but she added that this support would have been lost if the bill was amended to include mature minors.

Some CPC MPs were upset that the bill even alluded to the possibility. Marilyn Gladu (2016, May 2), who worked with youth for thirty years, called the eligibility of mature minors “a dark path.” Gladu, Cooper (2016, April 22), and Deltell (2016, May 2) all refer to the *Carter v. Canada (Attorney General)* ruling. They all note that the SCC did not mention minors. Cooper (2016, April 22) states: “If the Supreme Court contemplated minors, the Supreme Court would have said so, but it did not say that. It was very clear in saying [‘]competent adult person[’][.]” Some Senators shared this sentiment as well. The Honourable Don Meredith (2016, June 15) mentioned the ruling

on the last day of the third reading. He stated that not allowing minors is “obvious” and that the SCC “repeatedly and deliberately” used the term “competent adult[.]” Similarly, the Honourable Denise Batters (2016, June 2) claimed that the SCC was clear and obviously did not intend to allow minors to be eligible for PAD.

Some MPs and Senators gave other reasons why the inclusion of mature minors should not be considered. Some shared procedural concerns. CPC MP Deltell (2016, May 2) asked who would be able to make the final decision if this extension were to become a reality: “In the worst case scenario, if a 17-year-old child asks for end of life care, which his father wants but not his mother, who is right?” Others referred to the rationale of other age-based laws. Dean Allison (2016, May 3), another CPC MP, stated that the government created the *Youth Criminal Justice Act* based on “the medically accepted fact that the human brain is not fully developed until around the age of 18.” Batters (2016, June 2) referred to the legal voting age. Lastly, the Honourable Senator Terry M. Mercer (2016, June 8) worried about the “unintended consequence” of the “message we’re sending to the young people of this country.” He referred to areas, including Woodstock and Oxford County of Ontario, which have had bouts of young people committing suicide. Other MPs and Senators urged that the age restriction ought to be re-examined.

More CPC MPs were against the possible extension to mature minors than NDP MPs. NDP MP Brigitte Sansoucy (2016, May 2) stated that they were told to interpret the SCC decision “as a floor” and criticized the CPC for interpreting it as “a ceiling” and the LPC for drafting legislation “below the Carter ruling... and down into the basement[.]” She said that, as member of the PDAM, she heard from medical experts who had patients who were minors that had “a degree of maturity” not even achieved by some adults. She

did, however, agree that reviews need to take place first. The Honourable Senator Claudette Tardif (2016, June 2), while acknowledging that age of consent is important, argued that setting the eligible age to eighteen simply “because our society considers that to be the age of majority is perhaps not the best approach.” Thus, while some, mostly CPC MPs, thought that the mere study of extending MAID to mature minors was ill-founded, others agreed with a need for further study of the possibility.

Advance Requests

Wilson-Raybould (2016, April 22) defined advance requests: “where a person makes a request in advance for a form of treatment that they would want if they lose their ability to express their wishes[.]” Even before amendments were made, Bill C-14 (2016a, 2016b, 2016c) never allowed advance requests. More specifically, s. 241.2 (3) (h) of the *Criminal Code* lists a safeguard that prevents such requests: “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” (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). Consequently, individuals with any condition that might impair their ability to consent, such as Alzheimer’s disease, are not eligible for MAID.

Similar to the topic of mature minors, LPC MPs sought a balance between opponents and supporters of MAID when it came to advance requests by not allowing them, on one hand, but ensuring the topic is given thorough study, on the other hand. Wilson-Raybould (2016, April 22) (LPC) stated that the SCC ruling restricted eligibility to individuals who can consent, and an individual who cannot “withdraw their consent to

die... would no longer clearly consent[.]” She added that advance requests are rare, but where they do occur, physicians are not likely to assist. Wilson-Raybould concluded, “More study of this complex issue is needed.” Casey (2016, May 2), another LPC MP, noted the “compressed time frame” to defend this approach. Even Julie Drabrusin (2016, May 2) (LPC), who thought Bill C-14 was “too restrictive” by not including advance requests, was at least content with the stipulation of future reviews.

Some Senators also agreed with this approach. The Honourable Peter Harder (2106, June 3) stated that there are three jurisdictions where advance requests of PAD are legal. Similar to Wilson-Raybould, he explained that in the Netherlands, in particular, PAD is rare when a patient can no longer expressly make requests due to physicians’ overall reluctance. He also added that the CMA claimed physicians already experienced trouble with providing advance requests. This is why he commended JUST for requiring that a review be initiated within 180 days. The Honourable Jaffer (2016, June 13) proposed an amendment that advance requests be allowed but only after two years of a review. This motion was, however, rejected (Canada, Parliament, Senate, 2016a). Meanwhile, some MPs and Senators did not want advance requests to be considered.

CPC MPs Cooper (2016, April 22), Genuis (2016, May 2), Harold Albrecht (2016, May 3), and Rachael Harder (2016, May 3) all agreed that advance requests should not be allowed at all. Cooper (2016, April 22) mentioned that the SCC restricted eligibility to those suffering at the time—“not persons who anticipate that they will suffer[.]” He also mentioned that Quebec’s Bill 52, which took a lot of time to draft and pass, initially included advance requests but legislators decided they would be too risky. Both Genuis (2016, May 2) and Albrecht (2016, May 3) disseminated the frightening

possibility of individuals initially requesting MAID but changing their minds when they can no longer express their consent. Furthermore, Harder (2016, May 3) invoked the concept of continuous consent, which is often invoked in sexual assault trials, and stated that it should also apply in cases of MAID.

In the other chamber, there were some Senators who agreed with these points. The Honourable Enverga (2016, June 13) spoke of the “very big difference” between advance requests in cases of WLST and MAID. He used the adverb “actively” to describe health care practitioners’ roles in MAID. Like Genuis and Albrecht in the other chamber, the Honourable Carignan (2016, June 13) spoke of the impossibility of changing one’s mind in these cases. There were, however, many MPs and Senators who thought advanced requests should be included in Bill C-14.

MPs across all party lines advocated for Bill C-14 to not just study advance requests but to also include them. CPC MP Kent (2016, May 2) states that they “must eventually be allowed[.]” LPC MPs Oliphant (2016, May 2), Pam Damoff (2016, May 2), and Arseneault (2016, May 2) all supported the inclusion of advance requests. More specifically, Oliphant (2016, May 2) stated, based on the demands of his constituency alone, that this is an issue that would be brought up numerous times. Without advance requests, Damoff (2016, May 2) mentioned that dementia patients, for example, would lack an option. Arseneault (2016, May 2) thought s. 241.2 (3) (h) was “too strict” considering the likelihood that individuals with grievous and irremediable medical conditions would by nature of their condition and perhaps by influence of their medication have trouble with giving consent. The NDP, however, were the most vocal when it came to allowing advance requests.

NDP MPs Rankin (2016, April 22), Wayne Stetski (2016, May 2), and Randall Garrison (2016, May 20), among others, also expressed their disappointment that Bill C-14 did not include advance requests. Rankin (2016, April 22), after noting that the PDAM recommended advance requests, stated that Bill C-14 without them “would offer those Canadians [who will lose their capacity to consent] nothing but the cruel choice the court spoke of, the choice between a death they consider premature and the rising fear of a life they consider intolerable.” Discontent over excluding advance requests was not limited to these three political parties. Similar to Rankin, GP MP and Leader May (2016, May 2) stated that s. 241.2 (3) (h) “goes against the very essence of what the Supreme Court of Canada said we must do[.]” BQ MP Thériault (2016, May 3) spoke about the various ways individuals with degenerative diseases can communicate that would make advance requests a viable option. It is clear that MPs had strong opinions on the inclusion, or rather lack thereof, of advance requests.

These strong feelings were not limited to the House of Commons. The Honourable Senators Nancy Ruth (2016, June 2), Victor Oh (2016, June 2), Baker (2016, June 8), and Pamela Wallin (2016, June 13), among others, all expressed their support of the inclusion of advance requests in cases of MAID. In fact, Ruth (2016, June 2) called the lack of advance directives “a failure to protect the patient” since it leads to “anxiety about loss of independence and helplessness.” Oh (2016, June 2) emphasized the importance of autonomy for those patients who will only get worse but are not considered terminal. Baker (2016, June 8) expressed his confusion over why every province allows advance requests in cases of WLST and palliative sedation, but that they would not be allowed in cases of MAID across Canada. Lastly, Wallin (2016, June 13) expressed her

confusion over why we would “forbid a competent and clear-headed person from stating in writing, in advance, their reasoned and desired decision[.]”

The Honourable Senator Cowan (2016, June 13) proposed an amendment to include advance requests and defended this motion on various grounds. Cowan (2016, June 8) mentioned the same dilemma Rankin mentioned. He even alluded to the possibility of individuals challenging the *Charter* in the future, stating that the bill “discriminates between people on the basis of disease” (Cowan, 2016, June 13). He also mentioned that both the PDAM and LCJC recommended advance requests. He cited polls that showed Canadians’ overall support of advance requests. Though this motion was, however, defeated by twenty-four votes, it is clear that the possibility of extending Bill C-14 to include advance requests was debated extensively in both chambers and will likely be debated again (Canada, Parliament, Senate, 2016a).

Mental Illness

S. 241.2 (1) (c) of the *Criminal Code* states that, in order to be eligible for MAID, one must have “a grievous and irremediable medical condition” (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). S. 241.2 (2) defines this type of condition. For example, it must result in “enduring physical or psychological suffering that is intolerable” and “natural death [that] has become reasonably foreseeable[.]” This last criterion means that those individuals suffering with mental illness alone are not eligible. At second reading, Wilson-Raybould (2016, April 22) (LPC) reminded the chamber that the SCC limited eligibility “to a competent adult person who clearly consents[.]” She added that “persons with psychiatric disorders would not fall within the parameters” of the ruling. It follows

then that, similar to two previously discussed issues, LPC MPs tended to stress the importance of directly responding to the SCC ruling for the time being and studying issues that fell outside of the ruling thereafter.

However, there were many MPs and Senators that are were opposed to even the possibility of extending eligibility to individuals whose sole condition was a mental illness. CPC MPs Deltell (2016, May 2), Mark Strahl (2016, May 2), Gladu (2016, May 2), and Larry Miller (2016, May 31), among others, were overtly opposed. Deltell (2016, May 2) stated it is “almost impossible” to ensure their consent. Similarly, on a later date, Miller (2016, May 31) alluded to the possibility that an individual may seek MAID in one state of mind and not in another. Strahl (2016, May 2) asked why the LPC wants to study the issue further in the first place, adding that “[w]e cannot allow the door to be opened even a crack[.]” Gladu (2016, May 2), who opposed the studies as well, mentioned depression as an example, noting that it could be treated but the needed medication often increases suicidal thoughts. Confusion over why Bill C-14 would allow for the study of this issue was shown in the Senate as well.

The most vocal Senator was Batters. Batters’ husband, who suffered depression and anxiety, committed suicide in 2009 (Kirkup, 2016, para. 3). It is not surprising, then, that she led the debate on this issue. Batters (2016, June 2) argued that individuals whose sole condition was a mental illness should not be eligible for MAID. She thought it was “curious” that Bill C-14 allegedly responds to the SCC ruling since this issue, in particular, was not relevant. And after hearing from many Canadians, she argued that extending eligibility in this way is not what Canadians want either. Using evidence from her experience being on the LCJC, she also discussed various aspects of mental illnesses

to show that, if anything, additional safeguards were needed to protect individuals afflicted with them. Mental illnesses, she explained, are typically treatable, but they are also complex and may require multiple treatments (Batters, 2016, June 2). She described their complexity. For example, not only could the “distorted thinking present in many mental illnesses” lead to an increase in suicidal thoughts, so could the needed medication. Furthermore, Senator Enverga (2016, June 2) gave an example of a group of mental illnesses that he feared one might possess and still qualify for MAID: eating disorders. This is why, he too, advocated for additional safeguards.

Not surprisingly, then, there were both MPs and Senators that sought additional safeguards to protect individuals who suffer with mental illness. From the beginning of second reading, CPC MP Cooper (2016, April 22) raised concern over the validity of the consent of those individuals who had both physical *and* psychological conditions. This is why he proposed that Bill C-14 be amended to require a psychiatric assessment for individuals who suffered both (2016, May 17). His proposed amendment failed. It was supported by 96 MPs, including 91 CPC MPs, 4 LPC MPs, and 1 NDP MP; and opposed by 225 MPs (Canada, Parliament, House of Commons, 2016a). In the other chamber, Senator Batters (2016, June 10) proposed that a “psychiatrist or psychologist should be required to assess a patient as part of the eligibility approval process” for individuals with mental illness. She also proposed that there be a ninety-day waiting period between requesting MAID and receiving it for these individuals. Her proposed amendment also failed (Canada, Parliament, Senate, 2016c). Though these amendments failed, it was clear that many CPC MPs and Senators were passionate about furthering safeguards for individuals whose consent may be impacted by mental illness.

While there were not as many MPs and Senators openly advocating the extension of eligibility to those whose condition was psychological only, some encouraged further study. Minister of Health Philpott (2016, April 22) (LPC) acknowledged the views on both sides, and this is why Bill C-14 adopted “a cautious approach” of future reviews. Wilson-Raybould (2016, May 31) (LPC) lists some organizations that support this approach prior to extending eligibility, including the Mental Health Commission of Canada. In response to Batter’s amendment above, the Honourable Senator Jane Cordy (2016, June 10) stated that she “would prefer that the minister do the study on the whole issue of mental illness[.]” In response to those wary about extending eligibility in this way and others, the Honourable Senator Kelvin Kenneth Ogilvie (2016, June 2) urged fellow Senators to read about a case from Alberta where a mentally ill individual was competent enough to make decisions. Since the proposed amendments to provide additional safeguards for the mentally ill ultimately failed, it is safe to assume that most MPs and Senators thought that risk was small and further review, as promoted by Bill C-14, was needed.

Theme 3: Ensuring Access

Before Amendments

Many MPs and Senators stressed the importance of including the protection of conscience rights of health care practitioners. Prior to amendments made by JUST, Bill C-14 (2016a) explicitly mentioned health care practitioners’ convictions once and in the preamble: “And whereas the Government of Canada has committed to develop non-legislative measures that would... respect the personal convictions of health care

providers[.]” LPC MPs Tassi (2016, May 2) and Casey (2016, May 2) alluded to this preamble to allay worries that health care practitioners’ convictions would be compromised if the bill were passed the way it was introduced. Casey (2016, May 2) also added: “Importantly, nothing in Bill C-14 would compel health care providers to provide any assistance that may be contrary to their conscience rights.” However, many MPs were not convinced.

Most interestingly, MPs across party lines did not think the preamble was enough to protect unwilling health care practitioners from being forced to partake in MAID. CPC MP Albrecht (2016, May 2) called this a “weak commitment” while NDP MP Tracey Ramsey (2016, May 3) asked why the commitment was not included “directly in the legislation.” CPC MP Cooper (2016, April 22) and NDP MP MacGregor (2016, May 2) both cited Section 3 of the *Civil Marriage Act* (2005) as a precedent for including the protection of conscience rights and perhaps an example for future MAID legislation. MPs, mostly CPC MPs, shared their fears of what would happen if Bill C-14 were passed without legislative protection of conscience rights and the importance of protecting such rights.

Some spoke of the possible impact on the field of palliative care. On at least two occasions, CPC MP Genuis (2016, April 22; 2016, May 2) spoke of the possibility of unwilling health care practitioners leaving or being dissuaded from practicing in palliative care. Protection of conscience rights, he said, would “preserve the existing system of palliative care that we have” (Genuis, 2016, May 2). Similarly, CPC MP Mark Warawa (2016, May 2) stated that Canada already lacked health care practitioners. Not including conscience protection rights, he added, would make it worse. Others, like CPC

MP Strahl (2016, May 2) spoke of the strong convictions health care practitioners would have on MAID in particular, arguing that their conscience rights should be protected:

“I want to be clear that sometimes there is a religious bent, but often it is an ethical bent. It is people who have spent their entire lives, gone to school, sometimes for over a decade, to help save lives, who are now being told that part of the medical system is to provide assisted suicide... and they are morally or ethically opposed to doing so.”

Many LPC MPs argued that this is matter of provincial—not federal—jurisdiction. In addition to citing the *Carter v. Canada (Attorney General)* ruling and preamble of the bill as sufficiently protecting conscience rights, LPC MP Virani (2016, May 2) stated that “the federal government has an important role to play in maintaining universal access to insured health services, but the ultimate delivery of medical services is primarily a matter of provincial jurisdiction.” He then alluded to the efforts that the federal government had been making to ensure access to MAID and protect health care practitioners simultaneously.

More specifically, Casey (2016, May 2) (LPC), among other LPC MPs, noted the Minister of Health’s proposed “end-of-life care coordination system” that would accomplish these two goals. Chris Bittle (2016, May 2) (LPC) refers to this system, which would help eligible patients seeking MAID find health care practitioners who are willing to provide it, as “an appropriate balance between supporting patient access [and] respecting the conscience rights[.]” While CPC and NDP MPs sought the protection of conscience rights of health care practitioners, LPC MPs stressed provincial governments’

roles in protecting conscience rights and their duty to ensure eligible patients have access to MAID.

Some MPs, however, did not want to rely solely on the provinces to protect conscience rights. Cooper (2016, April 22) (CPC) argued, “The Government of Canada has a duty to protect conscience rights of physicians and allied health professionals.” He worried about the inconsistencies that may arise if this responsibility is left to the provinces and territories. Deltell (2016, May 2) spoke of the same fear ten days later. Both Genuis (2016, April 22) and the Honourable Tony Clement (2016, May 3), another CPC MP, provided an example. In Ontario, the College of Physicians and Surgeons has a policy whereby physicians are required to refer and, if needed, provide emergency services. Both mused as to whether MAID could eventually become one of these services. Bill C-14 was eventually amended to include protection of conscience rights, but some MPs and Senators did not think this amendment went far enough.

Subsequent Amendments

On May 12, JUST amended Bill C-14’s (2016b) preamble to specifically refer to the *Charter* protection of conscience rights: “Whereas everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*.” Furthermore, JUST also amended Bill C-14 by adding a clarification clause in section 241.2 (9) of the *Criminal Code*: “For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying” (s. 3). The final law appears this way as well (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3). While most MPs seemed to be more concerned about protecting the conscience rights of

physicians, there were some that wanted to extend this protection to health care institutions as well.

CPC MP Albrecht (2016, May 3) wanted institutional protection even before the clarification clause was added. Cooper (2016, May 17), another CPC MP, proposed an amendment to this effect. On May 30, 2016, while Motion No. 14 received the support of all of the CPC MPs, 222 MPs voted against it (Canada, Parliament, House of Commons, 2016a). A similar proposed amendment also failed in the Senate. The Honourable Senators David Tkachuk (2016, June 2) and Betty Unger (2016, June 2) both advocated for stronger protection of conscience rights and the extension of these rights to institutions. In agreement, the Honourable Senator Donald Neil Plett (2016, June 9) proposed an amendment that no one “shall compel an individual or organization to provide or assist in providing medical assistance in dying or to provide a referral...” He also added that to do so is an offence. However, the conversation in the Senate focused more on the referral part of his proposed amendment than the addition of “organization.”

Senator Plett (2016, June 9) used various quotes from health care practitioners to show the need for additional protection when it comes to referrals. This included a quote from Dr. Blackmer from the CMA. Using these quotes, Plett shows that some health care practitioners, even if they freely refuse to provide or help provide MAID, feel complicit simply by making a referral. For example, Plett stated that Dr. Blackmer described a referral as “an endorsement of a procedure” and explained that many practitioners find this “morally problematic.” Plett fears that, while health care practitioners may be able to freely refuse to provide or help provide MAID, individual provinces and medical associations will require health care practitioners to make referrals. The Honourable

Senator Yonah Martin (2016, June 9) supported this proposed amendment as a way to provide consistency across the provinces and territories.

Other Senators expressed the fear of stepping on provincial terrain. This included the Honourable Senator Joyal (2016, June 9), who listed the provinces' and Yukon's policies on referrals. In doing so, he made the point that since referrals are promoted throughout Canada, this type of amendment would "make an offence out of something that is currently part of the practice of medicine." In addition, the Honourable Senator Lankin (2016, June 9) stated: "[R]egulation of health care practitioners and what health care practitioners must or must not do, within the respect for their rights under the Charter — and conscientious objection is already an acknowledged right within that — rests at the provincial level." To Plett's dismay, this amendment did not pass (Canada, Parliament, Senate, 2016b). In conclusion, while there was an expressed need to protect health care practitioners' ability to on religious or ethical grounds object to MAID, this need had to be balanced with patients' rights to access MAID and the province's control over health care delivery.

Importance of Themes

These themes will inevitably re-emerge. In fact, they already have. Their re-emergence will be discussed in Chapter 5. Before I discuss specific examples of their re-emergence, I will speculate what theme was and will be the most important. Bill C-14's compliance, or lack thereof, with *Carter v. Canada (Attorney General)* is a theme that is significant for many reasons. Bill C-14 was the Government of Canada's response to the SCC decision, so its compliance with it is vital. Moreover, it is evident that the

‘reasonably foreseeable death’ clause was the component of Bill C-14 that many of those who voted against the bill had the biggest issue with. And though a free vote was held (Wherry, 2016, para. 2), party lines became distinct when discussing this clause. For example, BQ MP Thériault (2016, June 16) explained that the Senate’s amendment to remove the clause was also supported by the BQ, GP, and NDP. This support was reflected in voting records, with 0 BQ, GP, and NDP MPs voting for Bill C-14 after the Senate’s amendments were rejected (Canada, Parliament, House of Commons, 2016c). Evidently, a change in government would have resulted in a different law despite the free vote. As one will see in Chapter 5, the frequently stated prediction that the government would face a constitutional challenge due to Bill C-14 turned out to be correct.

CHAPTER 5

CONCLUSION

Summary

It is safe to conclude that medical assistance in dying (MAID) is a contentious topic. In Chapter 1, I provided background information on physician-assisted death (PAD), voluntary active euthanasia (VAE), and MAID. Even this brief introduction showed the increasing prominence of PAD and VAE's decriminalization and legalization around the world. I also provided the legislative and judicial history of MAID in Canada. This recap showed that *Carter v. Canada (Attorney General)* and Bill C-14 were certainly not the first attempts at permitting PAD in Canada. It is clear that the Supreme Court of Canada (SCC) and the Parliament of Canada are familiar with this topic.

In Chapter 2, I reviewed the literature on PAD, VAE, and MAID, highlighting the ethical, legal, and political dimensions of the debates. First, scholars debate the 'active' and 'passive' nature of PAD and VAE with other medical acts and with each other. Scholars also debate the possibility of risk and abuse with PAD and VAE. While some scholars think a blanket prohibition is needed to protect the vulnerable, others think PAD regimes with safeguards are sufficient to do so. Second, scholars provide legal arguments for and against PAD and VAE. In an effort to limit scope, this section focused on Canada and the United States. Some scholars agree with previous rulings upholding PAD and VAE prohibitions while others disagree and provide rationale for permitting PAD and VAE. Third, scholars provide the perspectives of patients, the medical community, and social movement organizations (SMOs). The literature has shown that patients overwhelmingly support PAD and VAE, especially when compared to physicians. The

literature has also acknowledged the importance of end-of-life care and expanding roles of nurse practitioners. Furthermore, while there are some SMOs that support or oppose PAD and VAE, the disability rights movement overwhelmingly opposes these acts. The literature, thus, shows the contention inherent in the topics of PAD, VAE, and MAID. I also discussed the gaps in the literature and how this thesis contributes to the literature.

In Chapters 3 and 4, I described my research. In Chapter 3, I discussed my methodology. My objective was to identify key areas of concern, or issues, as Bill C-14, or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, progressed through the House of Commons and the Senate. I applied a thematic analysis of the Hansard on Bill C-14 to fulfill this objective. In Chapter 4, I discussed my findings. I briefly described the *Carter v. Canada (Attorney General)* ruling and the proposed bill that is now a law. I then discussed these issues.

I referred to these issues as *themes*. The first theme concerned Bill C-14's compliance with the SCC ruling. While some parliamentarians saw the eligibility criteria required to seek MAID as complying with the SCC ruling and protecting the vulnerable at the same time, others thought the 'reasonably foreseeable death' clause was not restrictive enough and others thought it was too restrictive. The latter took issue with the criterion that the illness be 'incurable,' noting that this may force individuals to undergo unwanted medical treatments. The latter also took issue with the 'reasonably foreseeable death' clause, noting its ambiguity and divergence from the SCC ruling. Though amendments to remove this clause were proposed and even passed in the Senate, both criteria appear in the final law (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 3).

The second theme concerned Bill C-14's ability to ensure consent, focusing on its procedural safeguards and independent reviews. While some parliamentarians thought the safeguards were sufficient, others advocated additional safeguards. To defend the bill, parliamentarians listed the safeguards, compared the bill to other jurisdictions, and cited various groups that supported the bill. Some parliamentarians, however, were not convinced and proposed amendments; a notable proposal that ultimately failed in both chambers was that of some form of legal review. In addition, some parliamentarians appreciated the future study of MAID and mature minors, requests made in advance, and individuals with mental illness. Meanwhile, others advocated for the extension outright and others were opposed to even the prospect of these extensions. Excluding the five-day reduction in the days between requesting MAID and receiving it, the stipulation to ensure consent among those who struggle to communicate, and the inclusion of the promise of future studies beyond the preamble, Bill C-14's procedural safeguards and promise of future studies did not change between its first reading and attaining Royal Assent (Bill C-14, 2016a, s. 3, preamble; Bill C-14, 2016c, s. 3, 9.1).

The third theme concerned Bill C-14's ability to ensure access. The concern over the protection of health care practitioners' conscience rights led to amendments made to this effect. The concern, however, continued even after the amendment. Some parliamentarians wanted additional protections while others feared that amending the bill in this way would restrict access and step on provincial terrain. In both chambers, amendments for institutional protection were proposed but ultimately failed. Furthermore, while some parliamentarians worried about health care practitioners being forced to refer patients for MAID, others believed that this was matter of provincial

jurisdiction. Ultimately, Bill C-14 (2016c) included protection of health care practitioners' conscience rights in its preamble and s. 3, but even at Royal Assent, it provided no mention of institutional protection or preventing mandatory referrals.

I concluded Chapter 4 with the importance of the themes. Since Bill C-14 is Canada's first successful bill to regulate MAID and MAID is highly contentious, as discussed throughout this thesis, it is no surprise that the issues discussed in the House of Commons and the Senate will be issues that will be returned to in the future. Based on my analysis of the parliamentary debates, I speculated that the first theme, which concerned Bill C-14's compliance with the SCC ruling, was and will be the most important in terms of re-emergence. After discussing the limits and significance of my research, I will provide examples to show that all of the themes have re-emerged.

Limits

There were some limits to this research. While qualitative research has many advantages, Archer and Berdahl (2011) explain that qualitative research methods "require a greater degree of interpretation on the part of the researcher and are therefore more subjective" than quantitative research methods (p. 132). The research conducted for this thesis was strictly qualitative. And while I tried my best to conduct my research with impartiality and rigour, notably by meticulously following the steps listed in Chapter 3, my presence as a researcher is undeniable.

To be more specific, Braun and Clarke (2006) explain that the "flexibility" inherent in thematic analysis "means that the potential range of things that can be said about your data is broad." This could be a limit, they add, when choosing "what aspects

of... data to focus on” (p. 97). This is especially true for this thesis since the Hansard on Bill C-14 was extensive. Though the bill was debated in a relatively short period of time, from May to June, the contentious nature of MAID resulted in long, thorough discussions on Bill C-14 in both the House of Commons and the Senate (LEGISinfo, n.d., House government bill C-14 (42-1)).

I, however, chose my themes based on recurrence of each issue *as well as* application to my research questions. Moreover, I tried to broadly encompass as many issues as I could. For example, while palliative care and its place in the budget, or lack thereof, were brought up numerous times while discussing Bill C-14, I was more concerned about the legislation itself and the grounds on which MPs or Senators supported and opposed it. This flexibility is a limit in that it shows my presence as a researcher, but it could also be seen as an advantage in that I was able to provide more narrow and detailed answers to my research questions. Nevertheless, more rigour could have been achieved with the use of qualitative research software.

Significance

As explained in the Abstract, this thesis further enriches our understanding of a relatively new end-of-life care option in Canada and speculates the future of MAID legislation. Bill C-14, or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, is Canada’s first successful bill to permit and regulate MAID. And while the Parliament of Canada and SCC are no strangers to discussions on PAD, VAE, and MAID, as previously explained, this thesis brings insight on the issues and legislation currently relevant to the discussion. Therefore,

this thesis contributes to the literature by analyzing the passing of a recently enacted law regarding a historically contentious end-of-life care option in Canada.

Furthermore, the Minister of Justice and Minister of Health have begun independent reviews of the issues discussed in Chapter 4, and the Parliament of Canada will reconsider the law in its entirety in 2021 (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 9.1, 10). This thesis, thus, provides insight on issues that will inevitably, by law, be discussed again within four years. In fact, we likely do not need to wait that long. Various incidents since the passing of Bill C-14 have shown that the themes, or issues, analyzed in this thesis have already proven to be significant. This thesis will conclude with just some examples of the re-emergence of these themes.

Since the Passing of Bill C-14

Re-emergence of Theme 1: Constitutionality

As predicted by some parliamentarians cited in Chapter 4, Bill C-14 is already facing a constitutional challenge. Julie Lamb, a 25-year-old woman from British Columbia, began the challenge roughly ten days after Bill C-14 received Royal Assent (MacLeod, 2016, para. 1-2). Though Lamb suffers from spinal muscular atrophy and will ultimately be unable “to speak, walk, swallow and breath[,]” she does not fit the eligibility criteria stipulated by Bill C-14 (para. 2, 1). The British Columbia Civil Liberties Association, the same group that was involved in *Carter v. Canada (Attorney General)*, is leading this challenge (para. 4, 8). They argue that the ‘reasonably foreseeable death’ clause unfairly excludes individuals suffering from non-terminal

illnesses (para. 7). They also argue that even Kay Carter would not have been eligible (para. 9). This challenge began in the B.C. Superior Court in 2016, but only time will tell if this case will end up at the SCC (para. 4).

More recently, the Quebec government, motivated by concerns from organizations representing health care practitioners, sought clarification from the courts surrounding the ‘reasonably foreseeable death’ clause (Ha, 2017, para. 2, 1). Quebec’s Minister of Health Honourable Gaétan Barrette cited two cases in Quebec that show the controversy surrounding this clause (para. 2, 7). Being ineligible for MAID because his brain illness was not terminal, Jean Breault starved himself to the point that he was eligible (para. 8). Suffering from Alzheimer’s, Jocelyn Lizotte was also deemed ineligible, so her husband, François Cadotte, assisted in her death and was subsequently charged with second-degree murder (para. 7, 9-10). It is safe to assume that this theme will continuously re-emerge until the clause is removed or clarified.

Re-emergence of Theme 2: Ensuring Consent

One of Bill C-14’s procedural safeguards is the requirement of the signatures of two independent witnesses (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016). These independent witnesses cannot benefit, financially or otherwise, from the patient’s death; own or manage the health care institution in which the patient lives; or be one of the patient’s health care practitioners (s. 3). Seeing this requirement as a potential barrier for some people, Dying with Dignity Canada trains volunteers to be independent witnesses for those patients having trouble fulfilling this requirement (Grant, 2017, para. 2). In mid-January of 2017, these volunteers had already helped thirty-five patients fulfill their

request for MAID (para. 7). This is just one of the ways that the group is trying to overcome what they see as barriers. This group will be discussed again.

Independent reviews have already been undertaken on MAID and mature minors, requests made in advance, and individuals with mental illness; and any recommendations from these reports will be brought before the Parliament of Canada no later than 2018 (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 2016, s. 9.1). However, some of these issues are already being discussed. First, the Quebec government is studying the possibility of allowing advance requests (Woods, 2017, para. 1). The Federation of Quebec Alzheimer Societies, however, opposes this idea (para. 11). Second, suffering from mental illness, Adam Maier-Clayton was a well-known activist for extending MAID to individuals with mental illness (Cross, 2017, para. 8, 1). His recent self-inflicted death has re-sparked the conversation on this issue—namely, whether individuals with mental illness as a sole condition can or should be able to consent to MAID (para. 6, 12). These are just some examples that show that the re-emergence of the themes pertinent to this thesis.

Re-emergence of Theme 3: Ensuring Access

While many parliamentarians were satisfied with the protection of health care practitioners' conscience rights that Bill C-14 offered, some health care practitioners were not. For example, just after the bill received Royal Assent, almost five thousand Christian physicians in Ontario challenged the provincial requirement of effective referral, "arguing [that] the referrals are morally equivalent to participating" (Fine, 2016, para. 1). Effective referral occurs when a physician refers a patient to a health care practitioner who is willing and available to provide a service (para. 6). This is why the

Coalition for HealthCARE and Conscience, a group of physicians, is campaigning that provincial law be amended to explicitly allow them not to refer (Janus, 2017, para. 3, 2). While these two examples are from Ontario, it is safe to assume that the burden of referring patients to other health care practitioners is felt among other health care practitioners in other provinces that require such referrals as well.

Some institutions are also unwilling to participate in MAID. In Windsor, Hotel-Dieu Grace Healthcare refused to fulfill a patient's request (Jarvis, 2017, para. 2-3). In Winnipeg, two faith-based institutions may refer patients to other institutions that provide MAID but will not provide it themselves (Macdonell, 2016, para. 4, 1). In Vancouver, Ian Schearer requested MAID, but the faith-based institution in which he lived refused his request (Blackwell, 2016, para. 1-2). To fulfill his request, he transferred to another institution, which, as described by his daughter, consisted of a "cross-town trip and inadequate pain control" that led to a painful end for Schearer (para. 3). To prevent these types of situations, Dying with Dignity Canada (2015) started the Shine a Light Campaign. They encouraged volunteers to call health care institutions, gather information on their MAID policies, and give this information to the group to contribute to an online map that will inform Canadians who offers MAID and who does not. It is, thus, clear that though health care practitioners can opt out of providing MAID, the law is not clear on referrals or institutions. Until the Act is amended or *all* provincial legislatures provide more clarity, these issues, or themes, will likely persist.

Concluding Remarks

This thesis was written within the first year that Bill C-14, or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, was passed and MAID became an available end-of-life option for some Canadians. This thesis sought to analyze the issues that were relevant as Bill C-14 was drafted and the Parliament of Canada debated it. And as one has seen, these issues have re-emerged since the bill was passed as a law. Since MAID is a contentious topic that is becoming increasingly relevant in the age of medicine and is one that will affect all Canadians at some point in their lives, either directly or indirectly, it is only a matter of time before the topic is revisited. It is, therefore, clear that Bill C-14 is likely just the beginning of MAID legislation in Canada.

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