Article

# *How to Legalize Medically Assisted Death in a Free and Democratic Society*

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**Abstract:** In 2015, the Supreme Court of Canada struck down the criminal law prohibiting physician assisted death in Canada. In 2016, Parliament passed legislation to allow what it called 'medical assistance in dying (MAID).' The authors first describe the arguments the Court used to strike down the law, and then argue that MAID as legalized in Bill C-14 is based on principles that are incompatible with a free and democratic society, prohibits assistance in dying that should be permitted, and makes access to medically-assisted death unnecessarily difficult. They then propose a version of MAID legislation ('Ideal MAID') that gives proponents and opponents of MAID everything they can legitimately want, contend that it is the only way to legalize MAID that is compatible with a free and democratic society, and conclude that it is the way to legalize MAID in Canada and other similarly free and democratic societies.

**Keywords:** withholding/withdrawing life-sustaining treatment; medical assistance in dying (MAID); safeguards; Ideal MAID

Charles Dickens opens *A Tale of Two Cities* (1859) with the sentence: "It was the best of times, it was the worst of times." Something like this is also true of Canada's medical assistance in dying (MAID) legislation. As legislation written with the aim of passing Parliament, it is arguably the best that could have been produced. But as legislation written to provide medical assistance in dying, it is awful. Section 1 below describes the arguments by which the Supreme Court of Canada legalized what it called "physician assisted death" and is now called MAID. Section 2 critically examines Bill C-14, that puts the Court's judgement into effect, and finds it wanting in both its foundation and details. Section 3 proposes a version of MAID legislation ('Ideal MAID') that remedies these faults, argues that it gives those who support and those who oppose MAID everything they can legitimately want, and contends that it is the only MAID legislation that is consistent with the principles of a free and democratic society. As such, we conclude that Ideal MAID is the way to legalize MAID in Canada and other similarly free and democratic societies.

## SCC on PAD

The Supreme Court of Canada (SCC) in C*arter v. Canada* (*Attorney General)*, 2015 SCC5,[1] ruled that any competent adult who has a grievous condition, experiences suffering that is intolerable and irremediable in any way acceptable to the person, and makes an in-person voluntary and informed choice, is entitled to physician assisted death (PAD). The Court went on to explain that "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may

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be sought."[2] The SCC thus left open the possibility of extending PAD to other populations besides contemporaneously consenting competent adults, and for other reasons besides extreme suffering.

The SCC judgement rests squarely on Section 7 the *Canadian Charter of Rights and Freedoms*,[3] according to which "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." The Court found the blanket prohibition of PAD infringes all three of these rights. The right to life is infringed by forcing individuals who anticipate a dreadful natural death, and a time that they will no longer be able take their own lives, to end their lives prematurely; liberty rights are infringed insofar as disabled persons cannot lawfully do what others can, namely commit suicide; and security rights are infringed because those who do not end their lives preemptively will have to endure a dreadful death.

Standing in the way of legalizing PAD, however, are two familiar objections. The first is that physicians must never kill. But the Court swept this aside with the comment that the "preponderance of the evidence of ethicists is that there is no ethical distinction between physician assisted death and other end-of-life practices whose outcome is highly likely to be death."[4] The second is that legalizing PAD would pose unacceptable risks, and in the British Columbia Supreme Court (BCSC), from which the case was on appeal, the government of Canada identified two forms of such risks.

The first is risk to patients. The worry here is about whether physicians can be sufficiently sure that patients requesting PAD are competent, and their decisions are "voluntary, informed, not ambivalent, and not compromised by social vulnerabilities such as age or disability."[5] On this matter, the SCC (following the trial judge in the BCSC case) found that patients "can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making," and concluded that: "Logically speaking, there is no reason to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying."[6] Thus, the Courts ruled that it is not possible to justify permitting physicians to withhold life-sustaining treatment (WLST) and provide palliative sedation while prohibiting them from providing PAD on the basis of risk to the patient.

The second risk Canada identified is risk to society because of what legalizing PAD today may lead to tomorrow. But the SCC dismissed this as well, commenting that: "The trial judge (in the BCSC) after an exhaustive review of the evidence rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide. We should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse."[7]

The SCC thus concluded that PAD should be legal for individuals facing serious suffering in the circumstances it outlined in its judgement, and left it to Parliament to write the legislation. The result was Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, enacted into law on June 17, 2016.[8]



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**Bill C-14**

Bill C-14 follows the SCC in requiring that candidates for MAID be competent adults who

a) "have a serious and incurable illness, disease or disability"[9]; and
b) "that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable."[10]

But it adds two new conditions not given by the SCC, stipulating that the patients

c) "are in an advanced state of irreversible decline in capability"[11]; and
d) "their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining."[12]

C-14 also required that special safeguards be attached to MAID. These stipulate that requests for MAID be:

a) made in writing after the person was informed that his or her natural death is reasonably foreseeable;
b) signed and dated in the presence of two independent witnesses;
c) accompanied by a written opinion by a second independent medical practitioner or nurse practitioner confirming the person's eligibility;
d) made at least 15 days before provision of MAID (unless both practitioners agree that death or loss of capacity to consent is imminent);
e) confirmed immediately before providing MAID.[13]

These additions to the SCC ruling raise three problems.

*Inappropriate Balance between Preserving Autonomy and Protecting the Vulnerable*

In its *Legislative Background: Medical Assistance in Dying (Bill C-14)*, the government explains that the aim of C-14 is to "strike an appropriate balance between the autonomy of those individuals seeking access to medical assistance in dying and the interests of vulnerable persons and of society."[14] It is, however, not clear what "appropriate balance" means. It cannot simply mean that the benefits of MAID legislation outweigh its risks, for while this presumably would justify that legislation, it would not justify C-14. This is because C-14 imposes conditions of access to MAID that are not required to WLST. To justify these additional conditions on the basis of risk, it must be shown that there are greater risks in providing MAID than to WLST. But (as the SCC argued) this does not seem to be so. Systematic differences cannot be found in the seriousness, speed, certainty of outcome, or difficulty in evaluating risks to the patient, and it is not clear to what else one can look. If so, reasonable access to MAID requires no more onerous a process than to WLST.

Alternatively, "appropriate balance" perhaps could be taken to mean that besides evidence-based risks, the views of the public on the impact and appropriateness of MAID should be taken into account to yield (as the Canadian Medical Association



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put it) a "reasonable accommodation for all perspectives."[15] But if this is the aim of C-14, C-14 conflicts with the recommendations of the *Canadian Committee on Corrections* when (channeling John Stuart Mill's theory of liberty) it writes that: "No act should be criminally proscribed unless its incidence, actual or potential, is substantially damaging to society."[16] The conflict is sharp. Whereas this principle rules out, as absolutely irrelevant, restrictions on liberty based on things such as paternalism, religious doctrine, cultural tradition, received morality, and the likings and dislikings of the people, these are central to any Bill designed to provide an accommodation of all the perspectives in question. The conflict is also fundamental. In any free society worthy of the name, absent harm to others, the criminal law cannot force competent individuals to live according to the preferences of popular opinion, and the importance of such freedom is not to be underestimated. This is particularly so if (as in the case of MAID) giving those opinions legal effect imposes great harm on individuals.

### *'Irreversible Decline' and 'Death Reasonably Foreseeable' Inconsistent with SCC Section 7 Argument*

The second problem comes from the requirement that, to be eligible for MAID, patients must be in an "advanced state of irreversible decline in capability"[17] and have their natural deaths "reasonably foreseeable."[18] Patients who do not satisfy these conditions but are experiencing enduring, intolerable, and irremediable suffering are left with three options. They can take their own lives prematurely; they can stop eating until death by starvation occurs or their condition deteriorates so they qualify for MAID; or they can wait until they die from natural causes. C-14 thus forces on patients whose prognosis is reliably predictable—notably but not exclusively those suffering from ALS, spinal stenosis, and MS—exactly the unspeakably cruel choices that motivated the SCC to legalize PAD/MAID. Since no one can reasonably treat a choice between such invidious alternatives as a free choice, C-14 necessarily results in a violation of the life, liberty, and security person sections of sec. 7 of the Charter.

### *Special Safeguards Burdensome and Unnecessary*

Finally, the safeguards C-14 attaches to MAID are burdensome in that they threaten to:

1) Turn a private, deeply personal decision into a formal, institutional and at least partly public bureaucratic exercise.
2) Make access to MAID difficult. One witness in the BCSC testified that in Oregon "only people who are determined and effective are likely to proceed successfully through all the hoops."[19]; another testified, that: "Satisfying the requirement of the Washington Act requires effort and dedication"[20] (The conditions of access to PAD in these states are substantially the same as those required by C-14.)[21]
3) Retard the normalization of MAID as a standard option in end of life care, and thus impair the quality of that care.
4) Give opponents of MAID opportunities to put obstacles in its way by disguising moral and religious concerns as safety issues.



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These consequences could be accepted if special safeguards provided safety, but there is no reason to think that they do. In its examination of the efficacy of safeguards, the BCSC concluded that "the risks inherent in permitting PAD can be identified and very substantially minimized through a carefully designed system ensuring stringent limits that are scrupulously monitored and enforced."[22] But it is one thing to say that the risks *can* be controlled by special safeguards beyond those used to WLST, and another to say that such safeguards are *necessary* to control them. To insist on such special safeguards in the legislation, evidence of their necessity is required, but the only support the Court gave for asking for them is that every jurisdiction that allows medically assisted death has such safeguards.

It does not, however, follow that only regimes with safeguards over and above what is required to WLST meet the standard for being "a carefully designed system ensuring stringent limits." To draw that conclusion, we need to be able to say that if no such special safeguards were attached to MAID, there would be an unacceptable drop in safety. More than this, to make the evidence applicable to Canada, it has to be shown that there would be such a drop in safety in jurisdictions where physicians had a long history of being able to safely WLST without special safeguards. But since every jurisdiction that has MAID also has those special safeguards, there is no evidence for the counterfactual, and thus the examination of permissive regimes provides no evidence that special safeguards are required for the safe practice of MAID in Canada. The outstanding and unanswered argument against the need for special safeguards in Canada comes from conjoining the long-acknowledged fact that physicians can safely WLST without special safeguards and the SCC's own claim that there are no greater risks in providing MAID than to WLST.

In spite of all these objections, it may nonetheless still have been right for the government to proceed with C-14. The restrictions and special safeguards found objectionable above may not contribute to safety, but the public may well think they do, or otherwise have such fondness for them, that any legislation proposed that did not have them would not succeed. If the choice was either to back C-14 or forego MAID altogether, the government arguably made the right choice. We are deeply skeptical that those were the government's alternatives. But even if they were in 2016, better choices may be available in the future, and in anticipation of this we now present an account of the ideal way to legalize MAID. Whether this legislation is politically realizable is a separate question. We will suggest at the end that it is, but even if it is not, no one thinks that C-14 is the final word on MAID, and progress is possible only if there is some vision of what is ideal to guide it. That vision may also clarify and synthesize the evidence already presented for a less restrictive regime than Canada has adopted in C-1,4 and identify strategies to extend MAID and possible court challenges to it.

## Ideal MAID

Any proposal to legalize MAID will stir up conflict between proponents of strongly held and irreconcilable views. The common way to deal with such conflicts is to seek compromise, but this is not entirely satisfactory because it means that not everyone gets everything they want. By contrast, our legislative proposal (which we will call 'Ideal MAID') proceeds by enriching the choices of the conflicting parties and then letting them go their own way. On this view, physicians would be able to choose whether and when to provide MAID, and patients could choose a physician who



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will or will never provide MAID. The theory is thus that increased freedom of choice will enable the conflicting parties to live together without compromise or coercion, except insofar as coercion is needed to ensure freedom of choice, including protecting the vulnerable from coercion and other forms of abuse.

The first task in developing this account is to provide a list showing when physicians should be able to provide MAID. We can begin with the SCC's ruling that any competent adult who has a grievous condition, experiences suffering that is irremediable in any way acceptable to the person, and makes a contemporaneous voluntary and informed choice, is entitled to MAID. But MAID cannot be limited to *adults* who *contemporaneously* request it. The SCC's view that there are no greater risks in providing MAID than to WLST immediately extends the right to MAID to mature minors who can authorize physicians to WLST to prevent suffering, as well as to individuals who have made a valid advance directive to do the same. If the awfulness of suffering is to be taken seriously, MAID should also be available to those who are suffering as described above because of mental illness alone, and 'tiredness of life' or 'existential fatigue.'

Nor can access be limited to *voluntary* MAID, since substitute decisionmakers can also authorize physicians to WLST to prevent or eliminate suffering. Thus, MAID must be available for infants, children, adolescents, and incompetent adults in the charge of substitute decisionmakers. The view that there is no greater risk to provide MAID than to WLST further entails that the extension of MAID to these populations cannot require that the patient's condition be deteriorating or their death foreseeable. The reasons for MAID are also not exhausted by *suffering*. A second and equally important reason is to be able as much as possible to control the manner and time of one's death. This encompasses avoiding being in a permanent state of helplessness and dependency, of being unable to prevent distress to loved ones having to watch a marginal existence or lingering death, and of being able to leave others with favorable memories of themselves. These considerations have always been part of the moral case for legalizing MAID and are regularly and legally used by people who request their physicians to WLST. It is also in some ways more important to have them covered in any MAID legislation than suffering, for while palliative care can do much to prevent or eliminate suffering, it can do nothing to help with them.

Those are some of the main choices—the list does not pretend to be complete—that individuals who favor MAID could reasonably want. Equally important for those who oppose MAID would be a robust conscientious objection clause that exempts healthcare providers from taking part in it. This should allow them to decline to take part in MAID in any way whatsoever, or selectively absent themselves from any form they find objectionable. Some physicians, for example, might be willing to provide MAID to remove suffering caused by advanced cancer but not existential fatigue. Those who approve of MAID must welcome this legislation, and those who disapprove of MAID can only oppose it for religious reasons or to prevent those who want MAID from having it. But religion cannot be invoked in any country that recognizes the separation of church and state, and it is possible to prohibit patients from having access to MAID in a free and democratic society only if MAID will adversely affect the interests of others or society. This, however, requires a demonstration that those risks are real versus theoretical, that they are substantial, and that they cannot be controlled by milder measures than the criminal law.[23]

This proposed legislation also comes with two additional advantages. First, having the enhanced access to MAID described above removes an asymmetry of



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advantages that currently exists between opponents and proponents of MAID. As matters now stand, those who oppose MAID can always experience the death they want, namely, a natural (i.e., unassisted) death. But proponents of MAID cannot always have the death they want, namely an assisted death. There is thus an inequality in law similar to that between patients who can commit suicide and those who cannot. The practical effect of this asymmetry is that the views of those who can have the death they want are imposed on those who do not want that type of death, and that is impermissible in a free and democratic society. Broadening access to MAID removes this inequality so that both those who favour MAID and those who oppose it can die as they wish.

Second, the proposal can be given legal effect without the difficulty of writing complex legislation specifying procedures which, if followed, would immunize physicians from legal liability. Instead, the law could come into being simply by granting physicians the right to provide MAID in just those circumstances in which they think it appropriate to do so. MAID would then be permitted in exactly the way that physicians can currently WLST, i.e., unregulated by criminal law and without special safeguards. There would still be legal requirements that physicians could violate in providing MAID, just as there are when they WLST, and criminal prosecution and defense would run on parallel lines. The pioneer of this informal approach to legalizing MAID is Glanville Williams in *The Sanctity of Life and the Criminal Law.*[24]

Williams proposes that it would be up to the physician, if charged, to show that the patient was suitably suffering, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed by law. It is also arguable that physicians will act better if left to use their discretion and code of medical ethics rather than have to follow legal regulations which—witness C-14—can be arbitrary, hard to apply, and have repugnant consequences.

We propose Ideal MAID as the only MAID legislation that can provide every party with everything it can legitimately want and that is compatible with a free and democratic society. All that stands in its way is a suitable respect for the importance of freedom of choice, both for oneself and for others, in matters that materially affect only those parties. There is no suggestion that such respect will be easy to achieve. But once (or if) it is achieved, adopting Ideal MAID will be as natural as breathing, and accommodating those who hold radically different views on MAID under the law should pose no extraordinary difficulty. Finally, before anyone says that this legislation could never politically become a reality in Canada, they should recall that forty years ago it was illegal in Canada for physicians to WLST, and in 1983 the Canadian Law Reform Commission pronounced it impossible for Canada to ever have euthanasia.[25] Yet, here we are in 2018 with MAID in place, and the government entertaining the possibility of extending it to allow access by advance directives, mature minors, and those for whom mental illness is the sole cause of suffering.[26] Who, in the light of this, can confidently say that Ideal MAID in Canada can never be?

## Notes

1. Supreme Court of Canada. Supreme Court Judgments. Carter v. Canada (Attorney General) 2015 SCC 5, [2015] 1 S.C.R. 331; available at https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do (last accessed 24 Oct 2019).
2. See note 1, Supreme Court of Canada 2015, at paragraph 127.



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3. Government of Canada. Constitution Act, 1982; available at http://laws-lois.justice.gc.ca/eng/Const/page-15.html (last accessed 24 Oct 2019).
4. See note 1, Supreme Court of Canada 2015, at paragraph 23.
5. Supreme Court of British Columbia. Carter v. Canada (Attorney General), 2012 BCSC 886, 287 c.c.c. (3d) 1, at paragraphs 761–853.
6. See note 1, Supreme Court of Canada 2015, at paragraph 115.
7. See note 1, Supreme Court of Canada 2015, at paragraph 120.
8. House of Commons. Statues of Canada 2016. http://www.parl.ca/DocumentViewer/en/42-1/bill/C-14/royal-assent (last accessed 24 Oct 2019).
9. See note 8, Statutes of Canada 2016, at 241.2 (2)(a).
10. See note 8, Statutes of Canada 2016, at 241.2 (2)(c).
11. See note 8, Statutes of Canada 2016, at 241.2 (2)(b).
12. See note 8, Statutes of Canada 2016, at 241.2 (2)(d).
13. See note 8, Statutes of Canada 2016, at 241.2 (3).
14. Government of Canada. Department of Justice. *Legislative Background: Medical Assistance in Dying (Bill C-14), at* 6.
15. Canadian Medical Association. "Principles-based Recommendations for a Canadian Approach to Assisted Dying," at paragraph 2.
16. Canadian Committee on Corrections. Basic principles and purposes of criminal justice. In: *Report of the Canadian Committee on Corrections. Toward Unity: Criminal Justice and Corrections*. Ottawa: The Queen's Printer; 1969.
17. See note 8, Statutes of Canada 2016, at 241.2 (2)(b).
18. See note 8, Statutes of Canada 2016, at 241.2 (2)(d).
19. See note 5, Supreme Court of British Columbia 2012, at paragraph 436.
20. See note 5, Supreme Court of British Columbia 2012, at paragraph 454.
21. See note 5, Supreme Court of British Columbia 2012, at paragraphs 673–87.
22. See note 5, Supreme Court of British Columbia 2012, at paragraph 883.
23. As required by the Canadian Committee on Corrections. See note 16, Canadian Committee on Corrections 1969.
24. Williams G. *The Sanctity of Life and the Criminal Law*. New York, NY: Alfred A. Knopf; 1957:339–40. Williams later comments that, alternatively, this onus could be reversed to require that it is up to the physician to show that the patient consented or (to accommodate nonvoluntary MAID we add) was a suitable candidate for MAID. James Rachels presents a version of this view in Rachels, J. *The End of Life*. Oxford: Oxford University Press; 1986:182–7.
25. Law Reform Commission of Canada, Report 20. *Euthanasia, Aiding Suicide and Cessation of Treatment.* Minister of Supply and Services Canada 1983:17.
26. See note 8, Statutes of Canada 2016, at section 9.1.

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