



From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada

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Abstract

In this paper, I offer a personal and professional narrative of how Canada went from prohibition to permission for medical assistance in dying (MAiD). I describe the legal developments to date and flag what might be coming in the near future. I also offer some personal observations and reflections on the role and impact of bioethics and bioethicists, on what it was like to be a participant in Canada's law reform process, and on lessons that readers in other jurisdictions might take from Canada's experience.

Keywords Medical assistance in dying · Assisted dying · Canada · Law · Policy · Bioethics

Introduction

In this special issue of *HEC Forum*, many of the key participants reflect on their experiences with the implementation of MAiD services and programs in Canada, and the role of bioethics in that process of implementation.

In this piece, I take one step further back in time. That is, I describe how we got to the place where bioethicists and clinicians got together to figure out how to deliver this incredibly charged, ethically complex, newly legal, health service. I then describe the legal developments that have taken place concurrently with the implementation and flag what might be coming in the near future. And, along the way, I offer some personal observations and reflections on the role and impact of bioethics and bioethicists, on what it was like to be a participant in Canada's law reform adventure, and on lessons that readers in other jurisdictions might take from Canada's experience.

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This is, of course, only one person's view on the history. It is my view, as someone trained in bioethics and law; a teacher, researcher, and activist who works in the faculties of law and medicine. I have been both a close observer of, and an advocate for MAiD in Canada for over two decades. I was the Special Advisor to the Special Senate Committee on Euthanasia and Assisted Suicide (Special Senate Committee on Euthanasia & Assisted Suicide, 1995) and a member of the *pro bono* legal team in *Carter v. Canada* (2015) and *Lamb v. Canada* (2016), the Royal Society of Canada Expert Panel on End of Life Decision Making (Schuklenk et al., 2011), the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Provincial-Territorial Expert Advisory Group, 2018), and the Council of Canadian Academies Expert Panel on Medical Assistance in Dying (Council of Canadian Academies Expert Panel, 2018).

I'm often asked why I got interested in MAiD and what has kept me fuelled throughout a long and often difficult engagement on this issue. There was no traumatic bad death of a loved one. Rather there was an early and sustained intuitive desire to fight for others. Early courses in Philosophy revealed the profound and intellectually challenging questions arising at the end of life (first withholding and withdrawal of potentially life-sustaining treatment, then advance directives, then MAiD). Personhood, autonomy, and vulnerability were the key concepts at the heart of my fascination. Training as a palliative care volunteer while an undergraduate student, instilled in me an awareness that there can be better and worse deaths and that we can and should fight to ensure the best death possible for everyone. Training in Law gave me the power, privilege, and tools needed to take on Canada's unjust prohibitions on MAiD.¹

Let's think of the story of Canada's journey to decriminalizing MAiD as a play. By times, I was an actor on the stage, for example when I was appearing as a witness before Parliamentary Committees or writing articles. By times, I was the playwright writing lines for someone else to deliver. By still other times, I was an audience member albeit one with a front row seat who could not see what was going on off-stage behind the wing curtains knowing all the while that incredibly important things were happening – the plot would mysteriously advance two steps or take an unpredicted swerve in one direction or other as, for example, when the government inexplicably narrowed the eligibility criteria for access to MAiD between the Supreme Court of Canada's *Carter* decision and Bill C-14 (detailed in Act 3). At the time of the drama, there was no reliable narrator telling us what had transpired (who had said or done what or, indeed, who had been a part of whatever happened to advance the action). Through having played these various roles or parts, this is my attempt, in retrospect, to piece together the plot.

Extending this metaphor, this article can be seen as a piece of dramaturgy. The play has already been written, I am elucidating for the audience its particularly affecting elements through setting the stage, interpreting the key characters and

¹ Assisted suicide was prohibited through the provisions on counselling or aiding suicide (s.241) and euthanasia was prohibited through the provisions on administering a noxious thing (s.245) and homicide (s.222) (*Criminal Code*, 1985).

themes, and imagining how this drama could be translated for the global stage to other jurisdictions contemplating decriminalizing assisted dying. What follows is a personal and professional narrative of how Canada went from prohibition to permission for MAiD. The drama unfolds in a prologue, four acts, and an epilogue representing distinct eras of MAiD in Canada. I include the major developments of each era, as well as my reflections on the role of bioethics and bioethicists as well as more general reflections on what happened. I end with some lessons that other jurisdictions may learn from the long and circuitous path Canada took towards decriminalization of assisted dying (see Appendix B, Legislative Timeline of MAiD in Canada, for graphic representation of a high-level summary of MAiD legal processes from the early 1990s to the mid 2020s).

Prologue (1990–2008)

Scene: Canada

In the early 1990s, a flurry of unsuccessful efforts were made to decriminalize MAiD through the federal Parliament (the *Criminal Code* is set by the federal government in Canada) (Downie, 2016). At the same time, Sue Rodriguez, a woman with amyotrophic lateral sclerosis (a degenerative neurological condition commonly known as ALS), took a case all the way to the Supreme Court of Canada (SCC). She argued that the Canadian *Criminal Code*'s blanket prohibition on assisted suicide violated her rights under the *Canadian Charter of Rights and Freedoms (Charter)*. In 1993, the SCC disagreed, by the slimmest of 5:4 decisions (*Rodriguez v. British Columbia*, 1993). The majority were swayed by arguments about: a consensus among “western countries” prohibiting assisted suicide; the legitimacy of the active/passive distinction; and the risk that permitting assisted suicide for competent adults would result in a slide down a slippery slope to involuntary euthanasia of the “vulnerable”.

In 1994, Svend Robinson, a Member of Parliament who had been present at Ms. Rodriguez' side during the court case and at her death by an (illegal but never prosecuted) assisted suicide (Robinson, 1997), made yet another attempt at legislative reform and introduced Bill C-215 *An Act to Amend the Criminal Code (Aiding Suicide)* (Bill C-215, 1994). It failed to gain any traction in the federal Parliament.

The next close call came in 1995 with a Special Senate Committee report on euthanasia and assisted suicide (Special Senate Committee on Euthanasia & Assisted Suicide, 1995). By a 4:3 margin it recommended keeping assisted suicide illegal and by a 5:2 margin keeping euthanasia illegal but establishing a less severe penalty where the killing was out of mercy or compassion. The majority were persuaded by arguments about respect for life and the principle of double effect, as well as concerns about voluntariness and “slippery slopes” (from competent to incompetent persons and from voluntary to non-voluntary euthanasia).

Despite all of these efforts at law reform and support for decriminalization from a majority of Canadians, MAiD was and would remain illegal. That isn't to say that MAiD wasn't happening in Canada. It was, but in a through-the-looking-glass way: MAiD was illegal, but people were doing it; the police knew, but people were either

not being charged or were being charged only to then receive suspended or very light sentences as part of plea bargains (Downie, 2016).

The project of law reform lay fallow for a decade after the Special Senate Committee report. However, in 2005 and again in 2008 and 2009, an MP from Québec named Francine Lalonde attempted to get a bill decriminalizing assisted suicide through the federal Parliament (Bill C-384, 2009; Bill C-407, 2005; Bill C-562, 2008). Although she was unsuccessful, the tide was about to turn.

Bioethics and Bioethicists

During this period, some bioethicists were writing academic papers about the legalization of MAiD (e.g., Downie, 1993) and engaging in debates within professional organizations (e.g., the Canadian Medical Association [Sawyer & Williams, 1994]). Bioethicists testified before the Special Senate Committee – both for and against MAiD (Special Senate Committee on Euthanasia & Assisted Suicide, 1995). However, Canadian bioethicists barely registered in *Rodriguez*.² That said, the case largely turned on the retention of the active/passive distinction and the principle of double effect (expressed in terms of “intent”) – topics covered in the academic bioethics and philosophy literature (cited by the court³). The majority held onto the distinction and principle and used them to justify finding that the prohibition on MAiD was consistent with the principles of fundamental justice (and was therefore not a breach of s.7 of the *Charter*). At a clinical level with respect to end of life care, bioethicists were not active regarding MAiD (this was unsurprising since it was illegal). Rather, they were focused on discussions and advocacy in relation to respecting refusals of potentially life-sustaining treatment. The leading court decision on that issue came in 1992 (*Nancy B v. Hotel-Dieu de Québec*, 1992) and so, inasmuch as they were working on end of life issues, bioethicists’ efforts were focused on moving the decision from one courtroom in one province to bedsides across the country.

Personal Reflections

Looking back at this 15-year period, I am most struck by the disconnect between politicians and the people they represented and between the law on the books and the law on the street. I used to be baffled by the question “Why would federal MPs not listen to their constituents who so overwhelmingly support decriminalization?” But then a seasoned politician gave me a primer on the phenomenon of single-issue voting and the risk of being targeted for defeat by single-issue voters and, while disappointing and disillusioning, it was no longer baffling.

I was and remain baffled by the question “How can it be that the *Criminal Code* would identify conduct as illegal and deserving of the most extreme sanctions and

² The majority of the Supreme Court of Canada quoted Edward Keyserlingk (on active/passive distinction) and Margaret Somerville (on palliative care that may shorten life).

³ For example, the SCC cited articles/reports by Ronald Dworkin, Glanville Williams, Edward Keyserlingk, and Margaret Somerville.

yet that conduct would not result in such sanctions?” It could, of course, have been compassion motivating police and prosecutors. But, alternatively, it could have been a fear of what would happen were a case to get to a jury—here the words of an Ontario Crown prosecutor testifying before the Special Senate Committee in the early 90s were revealing – “If we went to trial, we would see 12 common folk from Timmins kind of chart the course for euthanasia at this point in time” (testimony of David Thomas, 1994). The fear underlying this quote is that juries would exercise their capacity for jury nullification and would render criminal prosecutions unsuccessful and unpopular (Downie, 2016, 98). However, the promise of the quote is precisely the same thing. The characterization as fear or promise is, of course, in the eye of the beholder.

Act One (2009–2020)

Scene: Québec

Before explaining how MAiD came to be lawful in Québec, a few words of explanation are needed (especially for an international audience). First, it is important to understand the constitutional division of powers in Canada (*Constitution Act, 1867*). The criminal law is the domain of the federal government. The administration of the justice system (e.g., prosecutions) rests with the provinces and territories. The delivery of health services is also a matter of provincial/territorial jurisdiction. This division is what made it possible for the criminal law prohibitions on MAiD to be federal (and outside the reach of the Québec legislature) but the development of a regime for delivering end of life care (including but not limited to MAiD) to be provincial (and outside the reach of the federal government). Of course, the federal government could have challenged the Québec government’s assertion of jurisdiction over MAiD. They could have gone to court and argued that the Québec MAiD legislation was really an exercise of the criminal law power and therefore outside the authority of the province. They could have asked the court to strike down the Québec legislation as “*ultra vires*” (outside the jurisdiction) of the Québec legislature. But they didn’t.

And the reason for that probably relates to the second issue that demands a preparatory explanation – Québec’s special status within Canada. Québec is frequently (albeit controversially) described as a “distinct society.”⁴ It has, among the provinces and territories, unique institutions.⁵ It also sees itself as unique. This relates to

⁴ Although it must be noted that, despite attempts, this has not been officially recognized by the federal Parliament. <https://www.sqrc.gouv.qc.ca/rerelations-canadiennes/institutions-constitution/statut-qc/reconnaissance-nation-en.asp>. For a lay summary, see Jen-Philippe Warren and Simon Langlois, “Québec as a Distinct Society, The Canadian Encyclopedia <https://www.thecanadianencyclopedia.ca/en/article/Québec-as-a-distinct-society>.”

⁵ For example, there are two blood and other human biological products system management organizations in Canada: Héma-Québec (<https://www.hema-Québec.qc.ca/hema-Québec/profil/index.en.html>) and Canadian Blood Services (for the rest of the country) (<https://myaccount.blood.ca/en>).

history, culture, and language. In this context, this manifests itself in terms of being particularly progressive with respect to social issues. I've had Québeckers proudly describe a progressive trifecta – being in the vanguard in Canada with respect to abortion⁶ (Thomas, 1976), same sex marriage⁷ (*Catholic Civil Rights League v. Hendricks* 2004), and then MAiD—and tie this trifecta to the profound rejection of the oppressive role historically played in Québec by the Catholic Church (Durocher, 2013). To challenge Québec's jurisdiction to pass its own MAiD law, could well have been thought to be political suicide for any federal party hoping to remain in (Conservative Party) or regain (Liberal Party) power.⁸

With these prefatory comments behind us, cue the first law reform progress in Canada.

Lawful MAiD first came to Canada in Québec. In the Fall of 2009, following a report from its Working Group on Clinical Ethics (Groupe de travail en éthique clinique, 2008) two years in the making, the Québec College of Physicians unanimously adopted the Working Group Report and made public its position that euthanasia could be consistent with its Code de Déontologie (or Code of Ethics) and could constitute appropriate care (Collège des médecins du Québec, 2009). With this support in hand, the Québec government formed the Select Committee on the Right to Die with Dignity. The Committee conducted a phenomenally robust public consultation and deep dive into the experiences in other countries that had permitted MAiD for some years. They ended up recommending that MAiD be permitted and regulated, framing it as a legitimate part of end of life care (Select Committee of the National Assembly of Québec, 2012). Legislation was introduced May 22, 2014 and passed on June 5, 2014 (*Act respecting end-of-life care*, 2014). The legislation came into force on December 10, 2015. Despite the existence of a prohibition on MAiD in the federal *Criminal Code*, MAiD began to be provided in Québec in December 2015 (it could be provided without fear of criminal liability because there was a guidance to the Director of Criminal and Penal and the criminal and penal prosecuting attorneys acting on his behalf (effectively establishing that there would not be prosecutions so long as the Québec legislation was followed) (Government of Québec, 2015).

Key features of the Québec legislation include that a MAiD request must be free and informed, made by an adult with decision-making capacity who is at the end of life, suffering from a serious and incurable illness, in an advanced state of irreversible decline in capability, and experiencing constant and intolerable suffering that cannot be relieved by means acceptable to the person.

⁶ In 1976, the Minister of Justice announced that the Crown would not lay charges against doctors for performing clinic abortions.

⁷ In 2004, Québec became the third province to recognize same sex marriage.

⁸ This is, of course, an oversimplification of the socio-political-cultural situation in Québec. Justice to the complexity of the relationship between Québec and the rest of Canada cannot be done here. For more on why what happened in Québec happened, see Bouthillier, 2022 and Mona Gupta, 2021.

Box 1 An Act respecting end of life care (Quebec)

26. Only a patient who meets all of the following criteria may obtain medical aid in dying:

- (1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
- (2) be of **full age** and **capable** of giving consent to care;
- (3) be **at the end of life**;
- (4) suffer from a **serious and incurable illness**;
- (5) be in an **advanced state of irreversible decline in capability**; and
- (6) experience **constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable**.

29. Before administering medical aid in dying, the physician must

- (1) be of the opinion that the patient meets all the criteria of section 26, after, among other things,
 - (a) making sure that the request is being made **freely**, in particular by ascertaining that it is not being made as a result of external pressure;
 - (b) making sure that the request is an **informed** one, in particular by informing the patient of the prognosis for the illness and of other therapeutic possibilities and their consequences;
 - (c) verifying the **persistence** of suffering and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition;

One feature of the Québec legislation was particularly controversial – the eligibility criterion that one must be “at the end of life”. This feature was, unsurprisingly, challenged in court.

Nicole Gladu and Jean Truchon were two Québeckers with debilitating degenerative medical conditions that caused them constant and unbearable physical and psychological suffering that could not be relieved in a manner that they deemed tolerable. They were found to be ineligible for MAiD under the Québec law because they were not “at the end of life.” They argued that this eligibility criterion violated their *Charter* rights (*Truchon c. Procureur général du Canada*, 2017).

On September 11, 2019, Justice Christine Baudouin agreed with them, ruled that the “at the end of life” eligibility criterion did indeed violate the *Charter*, and struck it down (*Truchon c. Procureur général du Canada*, 2019). She declared that her decision would not take effect for six months to give the Government of Québec time to amend the law if it wanted to. The Government of Québec chose not to appeal the decision, to amend the law, or to seek an extension on Justice Baudouin’s decision coming into effect. “At the end of life” was therefore gone from the Québec law on March 11, 2020.

The Québec government recognized that the removal of “at the end of life” would open up access to MAiD, in particular for individuals with mental disorder as their sole underlying medical condition (MD-SUMC). They heard concerns expressed about potential difficulties with assessing the incurability of mental illness, the irreversibility of the decline in capability, and the irremediability of their suffering. Some opponents of MAiD MD-SUMC argued one could never declare a mental illness to be incurable or the suffering irremediable. Some argued one could not dissociate the illness from the desire for MAiD so a request for MAiD in the presence of mental illness could not be free and informed or the decision-maker capable. Some advocates for MAiD MD-SUMC argued that these concerns were

not supported by the available evidence or logic.⁹ The Association des Médecins Psychiatres du Québec was asked to develop recommendations for MAiD MD-SUMC (Advisory Committee on medical assistance in dying, 2020). The advisory document they produced does not dictate **whether** individuals can access MAiD MD-SUMC, rather, it provides guidance on **how** it should be implemented if legally permitted.

The Québec government has also been actively exploring the issue of requests for MAiD made in advance of loss of decision-making capacity. The Québec legislation requires that a person be capable of giving consent to MAiD immediately prior to its provision. This means that, for example, someone cannot request MAiD early on in the course of dementia, with the intention that the request be acted upon when they are in a late stage of their disease (i.e., no longer have decision-making capacity). An Expert Committee commissioned by the government recommended permitting advance requests (Groupe d'experts sur la question de l'inaptitude et l'aide médicale à mourir, 2019) and a Committee of the National Assembly is, as of November 2021, still considering the issue (Select Committee on the Evolution of the Act respecting end-of-life care, 2021).

Bioethics and Bioethicists

Bioethics and bioethicists played significant roles in the law reform in Québec (Gupta, 2021). Most unusually, the Working Group on Clinical Ethics of the College of Physicians played an important catalytic role. It may also have provided useful political cover. Here was an expert group recommending permitting MAiD. Here was a group of physicians speaking from the vantage point of ethics not law. This then had an important impact upon the way in which the legislation was developed. Rather than being cast as a battle between respect for autonomy and protection of the vulnerable situated in the courtrooms of the nation, it was cast as a component of care, situated in the physician–patient relationship (Groupe de travail en éthique clinique, 2008).

Personal Reflections

This Act left me with a deep appreciation of how law reform through a legislative process can happen constructively. I testified before the Québec Committee twice – once at the beginning of the process as they were scoping the issues and framing their work and once later on when they had draft legislation. I observed the passage of the legislation through the National Assembly and through a change in government. One thing stands out – the non-partisan, intensely consultative process. As I reflected on the experience immediately after I first appeared before the Committee, I was struck by the fact that I could not tell which party any particular Committee member had been from. It is commonplace when testifying before a legislative

⁹ For a full canvass and discussion of these concerns and responses to them, see Council of Canadian Academies Expert Panel on Medical Assistance in Dying, 2018.

Committee that one can tell the questioners' party affiliation by the ideology at or barely below the surface of their questions or by their attempts to score points through their "questions". Yet, that was not possible through this experience with this Committee. The members seemed to be asking questions to get information and advice, not to make or score points. They seemed to recognize the significance of their task and were committed to performing it without attention to partisan politics but rather with a full-throated commitment to acting in the public interest.¹⁰ When I feel bleak about partisan shenanigans in Parliament, I think back to the Québec process and take comfort in the knowledge that legislative law reform can be done differently and share this story with any Parliamentarian I can get to listen to me.

Act Two (2008–2016)

Scene: Canada (outside of Québec)

Meanwhile, in the rest of Canada, the table was being set for new attempts at federal law reform. For example, in "Rodriguez Redux", Simone Bern and I made and defended the claim that, while *Rodriguez* had failed 5:4, a new *Charter* challenge could now succeed (Downie & Bern, 2008). There were two main reasons for this. The first had to do with the law. Under the *Canadian Charter of Rights and Freedoms*, the right to life, liberty, and security of the person can be limited so long as this is done "in accordance with the principles of fundamental justice." New principles of fundamental justice that weren't available when *Rodriguez* was argued had been recognized since then. The new principles of "overbreadth" and "gross disproportionality" could be shown to be breached by the empirical evidence that it was possible to achieve the objectives of the legislation (largely "protect the vulnerable from ending their life in times of weakness") without prohibiting everyone from accessing MAiD. The second reason had to do with the empirical evidence itself. There had been decades of experience with MAiD in the Netherlands, Oregon and years in Washington State and Belgium. There was no convincing evidence of a slide down a slippery slope in any of these jurisdictions.

Then, in October 2011, the Royal Society of Canada Expert Panel on End of Life Decision Making released a report reviewing the empirical evidence as well as the legal and ethical arguments and recommending the legalization of assisted dying (Schuklenk et al., 2011). Significant for what was to come, the Panel concluded:

Despite the fears of opponents, it is also clear that the much-feared slippery slope has not emerged following decriminalization, at least not in those juris-

¹⁰ The non-partisan approach was even symbolically memorialized on the face of the Bill. The legislative process was started by one and finished by another government. Typically, if a Bill survives a change in government and is being made law, the name of the current Minister of the relevant department is on the Bill. However, this time, the current Minister made the decision to also include the name of the MNA who had led the process when she was the Minister (when her party was in power) – in recognition of her leadership on the matter.

dictions for which evidence is available. Nor is there evidence to support the claim that permitting doctors to participate in bringing about the death of a patient has harmed the doctor/patient relationship. What has emerged is evidence that the law is capable of managing the decriminalization of assisted dying and that state policies on this issue can reassure citizens of their safety and well-being. (Schuklenk et al., 2011: 90)

Soon thereafter, MAiD came to the rest of Canada through what is known as the Carter case.¹¹ Kay Carter was a woman with spinal stenosis, a painful degenerative spinal condition. She wanted, but could not access, MAiD in Canada so, in January 2010, she went to Switzerland where assisted suicide is legal. With that lived experience, her daughter and son-in-law decided to challenge the *Criminal Code* prohibition on MAiD. Gloria Taylor was a woman with ALS – the same disease Sue Rodriguez had had. She also wanted to be able to access MAiD when her life was no longer worth living to her and she joined in on the court challenge to Canada's prohibitions on MAiD. The British Columbia Civil Liberties Association also joined the case, standing in for all those whose rights were implicated but who could not themselves join the case as plaintiffs. Yet again, the plaintiffs argued that the *Criminal Code* prohibitions violate the right to life, liberty, and security of the person and the right to equality under the *Charter*.

The plaintiffs were successful at trial (*Carter v. Canada*, 2012), lost at the Court of Appeal (*Carter v. Canada*, 2013), but were successful at the Supreme Court of Canada (*Carter v. Canada*, 2015). On February 6, 2015, the SCC, in a 9:0 decision, held that the blanket prohibitions on MAiD found in the *Criminal Code* violated the *Charter*. The government had failed to demonstrate that, in order to meet its objectives (particularly protecting the “vulnerable”), it needed to prevent everyone from accessing MAiD. Rather, the SCC held, the objectives could be met while allowing access to MAiD for people with a grievous and irremediable medical condition causing enduring and intolerable suffering. The Court concluded:

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. [“irremediable” they added “does not require the patient to undertake treatments that are not acceptable to the individual.”] (*Carter v. Canada*, 2015: paragraph 147)

Honouring one of the limits on their role (that courts should not rule on matters not properly before them in the specific case) and the fact that the plaintiffs in the case were adults with decision-making capacity seeking to make contemporaneous

¹¹ While *Carter* was making its way through the court system, an MP and Senator introduced legislation in an attempt to decriminalize assisted dying. None of their attempts were successful – none even making it past second reading (Bill C-581, 2014; C-582, 2014; S-225, 2014).

requests for MAiD, and that their MAiD-motivating medical conditions were not mental disorders, the SCC also did not rule on the following issues:

- Should/can mature minors (individuals under the age of majority, 18 or 19 depending on the province or territory, who have decision-making capacity) be prevented from accessing MAiD?
- Should/can MAiD be prohibited where the request was made in advance of loss of capacity?
- Should/can there be special procedural safeguards put in place for cases involving individuals with a mental disorder as their sole underlying medical condition?

The SCC gave the federal government 12 months to amend the *Criminal Code* if they wanted to.¹² The federal Conservative government waited for five months before doing anything. Then they appointed an Expert Panel to “engage Canadians and key stakeholders in consultation on issues that are fundamental to a federal legislative response to the *Carter* ruling” and to “provide options for a legislative response to the *Carter* decision” (Department of Justice, 2015). Meanwhile, the provincial/territorial governments had appointed an Expert Advisory Group “to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying” as they would be responsible for implementing MAiD when the SCC decision came into effect (Provincial-Territorial Expert Advisory Group, 2018).

While these two groups of experts were working, a federal election was called and there was a change in government (from Conservative to Liberal). The new Liberal government changed the mandate of the federal Expert Panel, removing the request for options for a legislative response and leaving only summarizing the consultations (External Panel on Options for a Legislative Response to *Carter v. Canada*, 2015, 7). Then, a Special Joint Committee of the House and Senate of Canada was created to “consult broadly, take into consideration consultations that have been undertaken on the issue, examine relevant research studies and literature and review models being used or developed in other jurisdictions” (Special Joint Committee on Physician-Assisted Dying, 2016a, 2).

The Provincial-Territorial Expert Advisory Group and the Special Joint Committee made a number of remarkably similar recommendations of particular relevance to what the federal government ultimately introduced and what remain issues of particular contention.

Grievous and irremediable – both recommended against limiting eligibility to those with a terminal illness and, rather, for the Supreme Court of Canada criterion of “grievous and irremediable medical condition” to be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any

¹² The government could have chosen to do nothing (as they did after the Supreme Court of Canada decision in *R. v. Morgentaler*, [1988] 1 SCR 30 striking down the *Criminal Code* provisions on abortion).

means acceptable to the patient (Provincial-Territorial Expert Advisory Group, 2018, rec. 18; Special Joint Committee on Physician-Assisted Dying, 2016a, rec. 2).

Mature minors – both recommended against denying access to MAiD to mature minors (Provincial-Territorial Expert Advisory Group, 2018, rec. 17; Special Joint Committee on Physician-Assisted Dying, 2016a, rec. 6).

Advance requests – The PTEAG recommended that advance requests should immediately be permitted at any time following the diagnosis of a grievous and irremediable condition and once suffering becomes intolerable. They also recommended that “[w]ithin one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid” (Provincial-Territorial Expert Advisory Group, 2018, rec. 13). The Special Joint Committee recommended that advance requests should be permissible “any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable” (Special Joint Committee on Physician-Assisted Dying, 2016a, rec. 7).

Mental disorder as sole underlying medical condition – both the PTEAG and the Special Joint Committee recommended against psychiatric illness being an exclusion criterion for MAiD (Provincial-Territorial Expert Advisory Group, 2018, rec. 18; Special Joint Committee on Physician-Assisted Dying, 2016a, rec. 3).

The federal government decided that it could not meet the SCC’s February 2016 deadline and asked for an extension – to account for the time lost during the election. The SCC gave the government a four-month extension (*Carter v. Canada*, 2016). However, it also ruled that Québec was exempted from that extension so the *Criminal Code* prohibitions on MAiD were no longer be in force in Québec as of February 2016.¹³

The SCC also granted a constitutional exemption to individuals in the rest of Canada, allowing them to go to court, during the period of the extension, for a personalized authorization to access MAiD if they had a grievous and irremediable medical condition causing them enduring and intolerable suffering. At least 15 people accessed MAiD this way between February and June 2016.¹⁴

¹³ This didn’t change practice on the ground because, as per M-19, r. 1—Guidelines and measures of the Minister of Justice in matters of criminal and penal matters 17.2 <http://legisQuebec.gouv.qc.ca/fr/ShowDoc/cr/M-19,%20r.%201%20/>, there would be no prosecutions for MAiD provided after the Québec legislation came into force in December 2015 as long as the Québec legislative requirements were met.

¹⁴ *HS (Re)*, 2016 ABQB 121 (CanLII), 394 DLR (4th) 664, 29 ALR (6th) 106, [2016] AJ No 197 (QL), 263 ACWS (3d) 82 <https://canlii.ca/t/gnj3q>; *A.B. v Canada (Attorney General)*, 2016 ONSC 1912 (CanLII), 263 ACWS (3d) 919, [2016] AJ No 1389 (QL), [2016] OJ No 1389 (QL), 396 DLR (4th) 127, 129 OR (3d) 749, <https://canlii.ca/t/gnr79>; *Patient v. Attorney General of Canada et al.*, 2016 MBQB 63 (CanLII), 264 ACWS (3d) 368, [2016] MJ No 86 (QL), 129 WCB (2d) 257, 352 CRR (2d) 213, 82 CPC (7th) 295, 334 CCC (3d) 397, 328 Man R (2d) 36, [2016] 8 WWR 375, 396 DLR (4th) 351. <https://can->

Bioethics and Bioethicists

Bioethicists played an outsized role in Act Two. The Royal Society of Canada Expert Report, authored by a small group of bioethicists (with academic backgrounds in Philosophy, Law, and Medicine), laid a solid empirical and analytical foundation for what was to come (Schuklenk et al., 2011 and Sumner et al., 2020). The *Carter* case then turned in significant measure on the expert evidence provided by ethics experts. The plaintiffs relied on expert evidence from five bioethicists. The Attorney General on three. There is an entire section of the decision on “Medical ethics and medical end-of-life practices” (*Carter v. Canada*, 2012 at paragraphs 161–358). Justice Smith described the relevance of the ethical debate as follows:

Ethics is a discipline consisting of rational inquiry into questions of right and wrong; in this case, whether it is right, or wrong, to assist persons who request assistance in ending their lives and, if it is right to do so, in what circumstances. Since this case concerns arguments for physician-assisted death, a central question is whether it is ethical for physicians to provide such assistance. (*Carter v. Canada*, 2012 at paragraph 164)

Ethical principles have shaped both the law and medical practice. Ethical principles, similarly, enter into constitutional analysis (for example, Justice Sopinka referred to the positions of medical associations regarding the ethics of assisted suicide and euthanasia in his reasons in *Rodriguez* (at 608). (*Carter v. Canada*, 2012 at paragraph 165)

Justice Smith carefully explained why the ethical debates about MAiD bear on the legal and constitutional issues she had to decide. In the end, she concluded:

The preponderance of the evidence from 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. I find the arguments put forward by those ethicists, such as Professor Battin, Dr. Angell and Professor Sumner, to be persuasive. (*Carter v. Canada*, 2012 at paragraph 335)

In an individual case, whether based on a distinction between foreseeing and intending, on a distinction between acts and omissions, or on other grounds, a bright-line ethical distinction is elusive. (*Carter v. Canada*, 2012 at paragraph 338)

Footnote 14 (continued)

[lii.ca/t/gnzp7](https://canlii.ca/t/gnzp7); *A.B. v Ontario (Attorney General)*, 2016 ONSC 2188 (CanLII), [2016] OJ No 1601 (QL). <https://canlii.ca/t/gp2lp>; *A.A. (Re)*, 2016 BCSC 570 (CanLII), [2016] BCJ No 696 (QL). <https://canlii.ca/t/gp38q>; *W.V. v. Canada (Attorney General)*, 2016 ONSC 2302; *CD v Canada (Attorney General)*, 2016 ONSC 2431 (CanLII), [2016] OJ No 1871 (QL). <https://canlii.ca/t/gpddb>; *EF v Canada (Attorney General)*, 2016 ONSC 2790 (CanLII), 130 OR (3d) 711. <https://canlii.ca/t/gpq51>; *Canada (Attorney General) v E.F.*, 2016 ABCA 155 (CanLII), [2016] AJ No 505 (QL). <https://canlii.ca/t/grqkg>; *Patient 0518, Physician A0518 and Physician C0518*, 2016 SKGB 176; *M.N. v Canada (Attorney General)*, 2016 ONSC 3346 (CanLII). <https://canlii.ca/t/grt9c>; *I.J. v Canada (Attorney General)*, 2016 ONSC 3380 (CanLII), 131 OR (3d) 789. <https://canlii.ca/t/grt98>; *H.H. (Re)*, 2016 BCSC 971 (CanLII), <https://canlii.ca/t/grwh9>; *Tuckwell (Re)*, 2016 ABQB 302 (CanLII), <https://canlii.ca/t/grx1w>; *O.P. v Canada (Attorney General)*, 2016 ONSC 3956 (CanLII). <https://canlii.ca/t/gsm3g>.

I also find persuasive the arguments of Professor Sumner with respect to the absence of an ethical distinction between suicide and assisted suicide, if suicide is ethical. I agree that a distinction vanishes in the circumstances he specifies: the patient's decision for suicide is entirely rational and autonomous, it is in the patient's best interest, and the patient has made an informed request for assistance. The physician provides the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role. (*Carter v. Canada*, 2012 at paragraph 339)

The Provincial-Territorial Expert Advisory Group was constituted with a robust number of bioethicists (four of nine members). One of the two co-Chairs was a bioethicist. I think it is no coincidence (i.e., to put a very fine point on it, that so many members had graduate training in philosophy) that the final report provides a comprehensive overview of the issues—not focusing solely on MAiD or on the doctor-patient relationship but rather situating MAiD within the context of all end of life care, team-based health care, individuals/institutions/systems, and clinical care/research/education and that it provided an explicit “Statement of Principles and Values” upon which the recommendations were based and articulated the guiding “principles, values and existing rights, freedoms, responsibilities and obligations that exist within our health care system” as well as a “set of beliefs with respect to regulation” (Provincial-Territorial Expert Advisory, 2018, 18).

The Special Joint Committee of the House and Senate heard from a number of bioethicists (Special Joint Committee on Physician-Assisted Dying, 2016b). Of course, again, some were arguing for greater access and others for less. It is worth noting that the Committee ultimately made recommendations largely consistent with the *Carter* decision and the Provincial-Territorial Expert Advisory Group Final Report (both heavily influenced by bioethicists).

Personal Reflections

I emerged from this period in a state of optimism. A monumental decision had been rendered by the SCC. A period of thoughtful reflection on moving from the decision to a legislative regime by people with lived experience, academic experts, clinicians, regulators, and other stakeholders had followed. There was remarkable convergence on the basic features most (but granted not all) people believed should be in the legislation. The future looked bright.

Act Three (2016–2020)

Scene: Canada (Including Québec)

On April 14, 2016, the federal government introduced Bill C-14 (*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*) (Bill C-14, 2016a). Key elements include the following.

*Box 2 Criminal Code of Canada post C-14***Eligibility for medical assistance in dying**

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

- (a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
- (b) they are at least **18 years of age** and **capable** of making decisions with respect to their health;
- (c) they have a **grievous and irremediable medical condition**;
- (d) they have made a **voluntary** request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- (e) they give **informed consent** to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition

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

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

The most surprising and controversial element of this Bill was the narrow definition of “grievous and irremediable medical condition”, especially the element that “natural death has become reasonably foreseeable.” The federal government took the words of the SCC in *Carter* and shrank their reach. Some individuals who were eligible for MAiD under the SCC’s decision, were no longer eligible under the federal legislation. Many (although not all [testimony of Dianne Pothier, 2016]) constitutional law scholars testified before the House and Senate Committees reviewing the Bill, telling them that it was not *Charter* compliant (testimony of Joe Arvai, 2016; testimony of Peter Hogg, 2016). The Chair of the Federation of Medical Regulators of Canada told the Committees that “[t]he language is too vague to be understood or applied by the medical provision and too ambiguous to be regulated effectively” (testimony of Douglas Grant, 2016). The Canadian Medical Association, on the other hand, said that “the CMA recommends that parliamentarians support the enactment of Bill C-14 as proposed and without amendment” (testimony of Cindy Forbes, 2016). The Member of Parliament who would later become the Minister of Justice and Attorney General of Canada voted against his own party because of the insistence on the inclusion of “reasonably foreseeable”: “As a professor of law in Canada for 20 years and a member of two Canadian Bars, I also worry about passing legislation that is at serious risk of being found to be unconstitutional” (Bryden, 2019).

Nonetheless, the federal government dug in its heels. With a solid majority in the House, the legislation initially passed with the narrow definition of “grievous and irremediable medical condition” intact (Bill C-14, 2016a). However, the majority of members of the Senate rejected the narrow definition and sent it back amended to the House (Bill C-14, 2016b). The House, however, held firm, rejected the amendment, and sent it back

to the Senate with the narrow definition back in (Bill C-14, 2016c). The Senate then stood down and accepted the legislation with the narrow definition intact (Bill C-14, 2016d).

Unsurprisingly, within ten days of the legislation being passed and coming into force, the legal team from *Carter* was back in a British Columbia court – this time arguing that the narrow definition of “grievous and irremediable medical condition” violated the *Charter* (*Lamb v. Canada*, 2016). On behalf of Julia Lamb, a young woman with a degenerative neuromuscular condition, they argued that the eligibility criteria of “serious and incurable” and “reasonably foreseeable” violated her ss.7 and 15 *Charter* rights.¹⁵

Some months later, Nicole Gladu and Jean Truchon went to a Québec court to argue that the “reasonably foreseeable” provision in the federal legislation violated their *Charter* rights (just as, as described earlier, they were arguing that the Québec legislation “at the end of life” was also unconstitutional) (*Truchon c. Procureur général du Canada*, 2017).

As a result of different rules of court procedure, *Truchon* was the first of the cases to be heard by a judge. On September 11, 2019, Justice Baudouin found that the federal legislation indeed violates the *Charter* and she struck down “reasonably foreseeable” (*Truchon c. Procureur général du Canada*, 2019). She gave the federal government six months to amend the law if they wished to do so. The federal government decided not to appeal and announced their intention to amend the legislation to take account of the *Truchon* decision. But an election campaign ate into the six months Justice Baudouin had given them. So, in February, the federal government asked the court for an extension. She gave them a further five months (until July 11, 2020) (*Truchon c. Procureur général du Canada*, 2020a). Then COVID-19 struck and all of the federal government’s energy and attention was diverted to responding to the pandemic. In June, the federal government went back to court and asked for a further five-month extension. This was granted, giving the federal government until December 18, 2020 before the *Truchon* decision would take effect, striking “reasonably foreseeable” from Canada’s MAiD law (*Truchon c. Procureur général du Canada*, 2020b). Again pointing to COVID-19, the government went back to court yet again in December seeking yet another additional extension and was given until February 28, 2021 (*Truchon c. Procureur général du Canada*, 2020c) and then, after still another request, until March 26, 2021 (*Truchon c. Procureur général du Canada*, 2021).

It is important to note that in her original decision, Justice Baudouin gave Nicole Gladu and Jean Truchon constitutional exemptions to the delay in coming into effect of her decision. They would immediately be entitled to access MAiD if they met all of the criteria other than “reasonably foreseeable.” Then, in her decision granting the first extension, Justice Baudouin also recognized that other people’s *Charter* rights were being violated with every passing day and so she ruled that “any person” should be allowed to go to court to seek a judicial authorization for MAiD if they met all but the “reasonably foreseeable” provision of the federal law. This path to MAiD was kept open by subsequent judges

¹⁵ By way of reminder, s.7 provides that “[e]veryone 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.” S.15(1) provides that “[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” (*Charter*, 1982).

when granting the federal government request for further extensions, going so far at the last extension as to formally note that the Attorney General had made an extraordinary commitment to cover the fees and disbursements of individuals who had to go to court for judicial authorizations (*Truchon c. Procureur général du Canada*, 2021, para 104).

As a result of *Truchon*, as of February 11, 2020, individuals had access through the courts to MAiD in Québec even if their natural death was not yet “reasonably foreseeable.” It was an open and contested question whether individuals in the rest of Canada could also seek judicial authorizations under the Québec decision;¹⁶ none are known to have tried. At least eleven Québeckers were given judicial authorizations for MAiD before the federal government passed its new legislation.¹⁷

Bioethics and Bioethicists

Bioethicists were involved in Act 3 in a number of ways. They testified before and submitted briefs to the House and Senate Committees on C-14 and argued for and against many aspects of the legislation (Standing House Committee on Justice & Human Rights, 2016; Standing Senate Committee on Legal and Constitutional Affairs, 2016). Because the drafting of C-14 happened behind closed doors and deliberations about whether to make or accept amendments to the Bill took place behind the curtain enveloping the Cabinet table, it is not possible to tell which, if any bioethicists had any impact. Of course, it is possible to tell which were unsuccessful in arguing for amendments but it is not possible to tell why.

Bioethics and bioethicists also played a role in *Truchon*. Key ethical issues before the court included: the concept of “vulnerable person”; and the relationship between “suicide” and “MAiD”. Given debates about competencies required for bioethicists that have occurred within bioethics communities around the world (Aulisio, Arnold, and Youngner, 2000; Baylis, 2010; Matsui et al., 2021), it is interesting to note that, of the six experts to whom the word “bioethicist” or “bioethics” was attached, only one had a PhD in philosophy (moral philosophy, specifically Kantian ethics). One was a physician with a masters in bioethics, one was a lawyer with a masters degree in law with a specialization in bioethics. Others were a theologian, sociologist, and physician with no evident academic training in bioethics. Notably, only one of the experts to whom the word bioethicist or

¹⁶ It was argued by the federal government that they could not. However, while Justice Baudouin expressly did not rule on the issue, she said that she did not “accept this argument for the purpose of granting the application for an extension” (at paras 23–24). She then included a footnote to a Québec Court of Appeal authority that could be taken to say they could (her footnote 25). For more on this issue, see Downie, 2020.

¹⁷ *Payette c. Procureur général du Canada*, 2020 QCCS 1604. <https://canlii.ca/t/j7ws2>; *C.V. et Trudel*, 2020 QCCS 1717. <https://canlii.ca/t/j80nm>; *Trudeau c. Procureur général du Canada*, 2020 QCCS 1863. <https://canlii.ca/t/j8bv1>; *Sinclair et Procureur général du Canada*, 2020 QCCS 3196. <https://canlii.ca/t/jb2db>; *Lessard et Procureur général du Canada*, 2020 QCCS 3189. <https://canlii.ca/t/jb2d7>; *Quenneville c. Procureur général du Canada*, 2020 QCCS 3397. <https://canlii.ca/t/jb7x2>; *Delorme c. Procureur général du Canada*, 2020 QCCS3935. <https://canlii.ca/t/jbt1k>; *Hénaire c. Procureur général du Canada*, 2020 QCCS 4018. <https://canlii.ca/t/jbvsvb>; *Ménard c. Procureur général du Canada*, 2020 QCCS 4460. <https://canlii.ca/t/jc9dc>; *Labbé c. Procureur général du Canada*, 2020 QCCS 4314. <https://canlii.ca/t/jc4q0>; *Jacob v. Attorney General of Canada*, 2021 QCCS 1086. <https://canlii.ca/t/jf1bv>.

bioethics was persuasive to the judge (the physician with a masters degree in bioethics). It is also interesting to note that the judge in this case was herself trained in bioethics (she has a masters degree in law with a concentration in bioethics from McGill University) and, when she practiced law before becoming a judge, she focused on health law, worked on various bioethical issues, and sat on hospital ethics committees. Justice Baudouin's willingness and ability to engage with the complex bioethical issues raised in the case were no doubt at least partly a function of her background training and experience in bioethics.

Personal Reflections

Act 3 left me angry and baffled. I was angry that some of the people who were given access to MAiD through *Carter* saw it taken away by the federal government through C-14. I was angry that the federal government passed a law that was so clearly unconstitutional and that individuals experiencing enduring, irremediable, and intolerable suffering were forced to go back to court to fight for their *Charter* rights and that the time and energy of their *pro bono* lawyers had to be spent on effectively relitigating MAiD instead of other public interest cases. I was angry that the federal government took language (“grievous and irremediable”) that had clearly established and discernible meaning (“grievous” is an established term in the *Criminal Code*¹⁸ and “irremediable” has a clear dictionary definition¹⁹) and confused everybody by introducing a criterion (“reasonably foreseeable”) that had established meaning but only in tort law (*Rankin (Rankins Garage & Sales) v. J.J.*, 2018) (and that meaning did not carry over to MAiD), that was impossible to define authoritatively even after an exhaustive review of various legal authorities (Downie & Scallion, 2018), and that so few of the people charged with providing or regulating MAiD understood (testimony of Douglas Grant and Joel Kirsh, 2016; testimony of Jeff Blackmer, 2016).

I was also baffled. Why did the government ignore the policy recommendations that came to them through thoughtful processes engaging experts and stakeholders, in particular the Provincial-Territorial Expert Advisory Group and the Special Joint Committee of the House and Senate? What evidence did they have that these processes did not? (And why not share it?) If not based on evidence, what logic did they have? (And why not share it?) Or were the deviations really the result of political calculus? Or the beliefs and values of key players at the Cabinet table? And where on earth did the phrase “natural death has become reasonably foreseeable” come from?

¹⁸ For example, in *R. v. Martineau*, 1988 ABCA 274 (CanLII), Chief Justice Laycroft stated: “The common law definition of ‘bodily harm’, substantially incorporated in s. 245.1(2) of the code, includes any hurt or injury which interferes with health or comfort; it need not be permanent but must be more than merely transient or trifling. The addition of the word ‘grievous’ to the term merely added the connotation of ‘serious’; in neither case would the injury necessarily be life threatening.” Reviewing the history, he stated that “Canadian courts had adopted the definition of ‘grievous bodily harm’ used by Willes J. in *R. v. Ashman* (1858) 1 F & F 88; 175 E.R. 688. The injury was not required to be ‘either permanent or dangerous; if it be such as seriously to interfere with comfort or health it is sufficient’: *R. v. Archibald* (1898) 1898 CanLII 124 (ON SC), 4 C.C.C. 159 (Ont H.C.); *R. v. Bottrell* (1981) 1981 CanLII 339 (BC CA), 60 C.C.C.(2d) 211 (B.C.C.A.).”

¹⁹ E.g., “causing or characterized by severe pain, suffering, or sorrow; ...; serious, grave.” <https://www.merriam-webster.com/dictionary/grievous>.

Act 4: 2020–2023

In January and early February 2020, the federal government held an online or mail public consultation and a series of roundtables with stakeholders (Government of Canada, 2020). The two-week public consultation resulted in over 300,000 responses. The stated goal was to get “Canadians’ views on the need for additional safeguards in a regime that will no longer be limited to dying persons, and on advance requests for MAiD” (Government of Canada, 2020).

Following these engagements, in February 2020, the federal government introduced Bill C-7 *An Act to amend the Criminal Code (medical assistance in dying)* (Bill C-7, 2020a).²⁰ This legislation was intended to do two things. First, to respond to the *Truchon* decision to strike down “reasonably foreseeable”. Second, to fix some problems with C-14 that had been identified as problems through the process of implementation and seemed relatively easy and uncontroversial to fix within the time available before *Truchon* would take effect.²¹

Most notably, and as it was required to do to be compliant with the *Charter*, C-7 removed “reasonably foreseeable” as an eligibility criterion. Unexpectedly, C-7 also introduced a narrowing of eligibility by saying that, for the purposes of determining whether the eligibility criterion of “serious and incurable illness, disease, or disability” is met, “a mental illness is not considered to be an illness, disease or disability” (Bill C-7, 2020a: s. 1(2.1)). This exclusion (effectively creating a barrier of MAiD for persons with mental illness as their sole underlying medical condition) was, presumably, a response to the concerns that some opponents of MAiD MD-SUMC had expressed about the potential impact on persons with mental illness of removing the “reasonably foreseeable” eligibility criterion (Government of Canada, 2020; Council of Canadian Academies Expert Panel, 2018).

After vigorous debate, persuaded by evidence and arguments responding to these concerns and with their attention squarely on the discriminatory impact of the exclusion, the Senate passed an amendment to automatically repeal the exclusion eighteen months after the coming into force of C-7 (known as the “sunset clause”). The House accepted the principle of the sunset clause but sent it back to the Senate amended to two years and the Bill passed in the House and Senate with the exclusion being automatically repealed in March 2023 (Bill C-7, 2020c). The Bill also mandated the Ministers of Justice and Health to commission an independent expert panel to review “recommended protocols, guidance and safeguards to apply to

²⁰ While this Bill died with an election call, it was brought back in the same form with the same number on October 5, 2020 (Bill C-7, 2020b).

²¹ Given space constraints, the following changes will be noted here but not discussed: reducing the number of witnesses required from two to one; dropping the ten-day reflection period between the formal request and the provision of MAiD; and modifying the reporting requirements (expanding who has to report, expanding reporting requirement earlier in process (before formal written request, after preliminary assessment), collection and analysis of data re: race, indigenous identity, and disability of persons requesting MAiD).

requests made for medical assistance in dying by persons who have a mental illness” and provide a report by March 2022 to the Ministers who would be required, in turn, to submit that report to Parliament (Bill C-7, 2020c: s.s 3.1 (independent review) and 5 (Parliamentary review)).

In response to the removal of “reasonably foreseeable” as an eligibility criterion, C-7 also made some changes to the procedural safeguards (Bill C-7, 2020c: ss 1(3)-(3.1)). C-7 established two tracks to MAiD with different procedural safeguards that depend upon whether the person’s natural death has become reasonably foreseeable.

Box 3 Criminal Code of Canada post C-7

Eligibility for medical assistance in dying

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:
(a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;

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

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

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

(e) they give **informed consent** to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition

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

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

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

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

(2.1) For the purposes of paragraph (2)(a), a mental illness is not considered to be an illness, disease or disability.*

*This provision will be automatically repealed in March 2023

People in Track One, face largely the same procedural safeguards as those previously eligible for MAiD under C-14. Notable changes are the reduction in the number of witnesses for the MAiD request (from two to one) and removal of the 10-day waiting period between the request and provision of MAiD.

Box 4 Procedural safeguards for Track One

(3) Subject to subsection (3.2), before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is 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, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
- (b) ensure that the person’s request for medical assistance in dying was
 - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
 - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
- (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before an independent witness who then also signed and dated the request;
- (d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;
- (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
- (f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;
- (g) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and
- (h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.*

* This requirement does not need to be met if the conditions set out in the provisions regarding final consent – waiver [section (3.2)] or advance consent – self-administration [section (3.5)] are met. See below for explanation of final consent waiver and advance consent.

People in Track 2 face more procedural safeguards than do those in Track 1. For example, if natural death is reasonably foreseeable, there is no mandatory period between request and provision but, if it is not, there is a 90-day reflection period (Bill C-7, 2020c: s.1(3.1)(i)). If natural death is not reasonably foreseeable, the person seeking MAiD must have been “informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care” (Bill C-7, 2020c: s.1(3.1)(g)) and both assessors and the patient must agree that the person has “given serious consideration” to those means (Bill C-7, 2020c: s.1(3.1)(h)). None of these hurdles in the path of access must be cleared by those whose natural death has become reasonably foreseeable.

Box 5 Procedural safeguards for Track 2

(3.1) Before a medical practitioner or nurse practitioner provides medical assistance in dying to a person whose natural death is not reasonably foreseeable, taking into account all of their medical circumstances, the medical practitioner or nurse practitioner must

- (a) be of the opinion that the person meets all of the criteria set out in subsection (1);
- (b) ensure that the person's request for medical assistance in dying was
 - (i) made in writing and signed and dated by the person or by another person under subsection (4), and
 - (ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;
- (c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before an independent witness who then also signed and dated the request;
- (d) ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;
- (e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);
- (e.1)** if neither they nor the other medical practitioner or nurse practitioner referred to in paragraph (e) has expertise in the condition that is causing the person's suffering, ensure that they or the medical practitioner or nurse practitioner referred to in paragraph (e) consult with a medical practitioner or nurse practitioner who has that expertise and share the results of that consultation with the other practitioner;
- (f) be satisfied that they and the medical practitioner or nurse practitioner referred to in paragraph (e) are independent;
- (g) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;
- (h) ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person's suffering and they and the medical practitioner or nurse practitioner referred to in paragraph (e) agree with the person that the person has given serious consideration to those means;
- (i) ensure that there are at least 90 clear days between the day on which the first assessment under this subsection of whether the person meets the criteria set out in subsection (1) begins and the day on which medical assistance in dying is provided to them or — if the assessments have been completed and they and the medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;
- (j) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and
- (k) 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.

* Safeguards in bold font are new for MAiD in Canada

** This requirement does not need to be met if the conditions set out in the provisions re: advance consent - self-administration [section (3.5)] are met. See below for explanation of advance consent.

C-7 also introduced some advance requests for MAiD. If natural death is reasonably foreseeable, the requirement of consent immediately prior to provision can be waived (i.e., requests made after the eligibility criteria have been met but in advance of loss of decision-making capacity can be respected) (Bill C-7, 2020c: s.1(3.2)). This amendment was catalyzed in large part by the powerful advocacy of Audrey Parker, a woman who died by MAiD earlier than she wanted to because she couldn't be confident that, if she waited, she would not lose capacity and therefore access to MAiD (hence the amendment is known as "Audrey's Amendment"). Before she died, she recorded a video and spoke with the media about the predicament the law placed her in (Dying with Dignity Canada, 2019). Her friends and supporters carried on her advocacy after she died.

Whether natural death is reasonably foreseeable or not, "advance consent" is permitted for cases of failed self-administration (in other words, if someone self-administers the drugs but it takes too long or doesn't work and they no longer have decision-making capacity, the provider can administer another set of drugs) (Bill C-7, 2020c: s.1(3.5)).

The Senate attempted to amend C-7 to allow for advance requests before all of the eligibility criteria are met (Bryden, 2021), but was rebuffed by the House (Speaker pro tempore, 2021). Instead, the final version of C-7 sent the issue of broadening access to advance requests to a new Joint Committee of the House and Senate to study and report back by March 2022 (Bill C-7, 2020c: s.5(1)).

C-7 also modified the reporting requirements (expanding who has to report, shifting the reporting requirements earlier in process (before formal written request, after preliminary assessment (Bill C-7, 2020c: s. 3(1)), and expanding what has to be reported and analyzed (collection and analysis of data re: race, indigenous identity, and disability of persons requesting MAiD) (Bill C-7, 2020c: s. 3(2)).

Bioethics and Bioethicists

The most startling thing about bioethics and bioethicists in this Act, is the apparent absence of bioethicists in a conversation loaded with bioethics. The Minister of Justice, Minister of Health, and Minister of Employment, Workforce Development and Disability Inclusion held a set of ten in-person roundtable consultations across the country. The report on these roundtables described the witnesses as follows:

These meetings allowed the three ministers to hear from over 125 experts and stakeholders on key issues. The experts and stakeholders included people from the following groups.

- Doctors and nurse practitioners
- Organizations that make rules about health care
- Key health stakeholders
- Legal experts
- Disability community
- Civil organizations

In addition, the ministers hosted a separate roundtable for Indigenous practitioners and community leaders. (Government of Canada, 2020: s. 3.0)

Bioethics and bioethicists were not included in this list. Of course some bioethicists are doctors, nurse practitioners etc. but it is noteworthy that bioethicists were not included as a distinct group.

The House Justice and Human Rights Committee heard from 34 witnesses (other than government officials) in its consideration of C-7 (Standing House Committee on Justice and Human Rights, 2020). Only one had a title that included the word bioethics or even ethics. The Senate Pre-Study of C-7 heard from 81 witnesses (including government officials) with three whose titles included the word bioethics or ethics. The Senate pre-study report described its witnesses as: “the Ministers of Justice, Health, and Employment, Workforce Development and Disability Inclusion; regulatory authorities; professional organizations; advocacy groups; people living with disabilities; academics, legal and medical practitioners and experts; Indigenous representatives; faith groups; caregivers; and other stakeholders.” (Standing Senate Committee on Legal & Constitutional Affairs, 2021: pg. 3)²² Only two had titles including bioethics or ethics. The Senate Legal and Constitutional Affairs heard from 66 witnesses including government officials in its consideration of C-7 and only two had titles including bioethics or ethics (Standing Senate Committee on Legal & Constitutional Affairs, 2021). There would be a handful of other individuals that one might classify as bioethicists digging into their backgrounds rather than relying on titles. However, definitely less than five.

The debates about C-7 included many bioethical issues including: whether individuals with mental illness as their sole underlying medical condition should have access to MAiD; whether individuals should be permitted to request MAiD in advance of loss of decision-making capacity; whether persons with disabilities as their sole underlying medical condition should have access to MAiD. Concepts such as autonomy, vulnerability, marginalization, paternalism, and equality were central to many of the debates and bioethics as a field has much to say about these concepts. Bioethics is surely relevant to public policy-making about such issues. Yet bioethicists seem to have been largely absent. Perhaps those issuing invitations to appear before the various committees felt that Canadian bioethicists had been heard from sufficiently in the past. However, new bioethical issues had arisen in C-7 and many of the witnesses who appeared on C-7 had been heard from before. Perhaps rather, this was a reflection of the fact that there is a relatively small number of bioethicists in Canada and the profound redirection of attention for many of them caused by the COVID-19 pandemic. Were they invited to appear but were too overwhelmed with such bioethical issues as vaccine allocation and critical care triage?

Personal Reflections

Act 4 left me relieved, optimistic, angry, disappointed, and baffled. Relief came from the removal of “reasonably foreseeable” – an eligibility criterion not found in the Supreme Court’s decision in *Carter*. What we had fought so hard for and won in *Carter*, only to see it eroded by the federal government, was given back by C-7. Relief also came from the inclusion of Audrey’s Amendment. No longer

²² It is telling that, like the government, they did not identify bioethics experts as a category.

would people have to reduce or decline pain medication in order to retain capacity through the ten day waiting period, no longer would people lose access to MAiD just because they unexpectedly lost capacity while waiting for a provider to arrive, no longer would people have to choose to end their lives earlier than they wanted to for fear of losing capacity and thereby losing access to MAiD and having to live through an extended period of enduring, intolerable, and irremediable suffering.

Optimism flowed from the process that gave us Audrey’s Amendment. The public spoke up, individuals whose loved ones were harmed by the lack of a “final consent waiver” spoke up, individuals who were choosing to die earlier than they wanted to spoke up. And what was remarkable is that the government listened. Audrey’s Amendment is a good example of policy-makers responding to public and expert comment on unintended consequences of legislation.

Unfortunately, the relief and optimism were followed by anger at the outrageously partisan nature of the House Justice Committee during the hearings on C-7 (Standing Committee on Justice and Human Rights, 2021). For example, one time the Chair moved the start of a meeting up by one hour with what the opposition members considered to be inadequate notice. The opposition members of the Committee proceeded to use up an entire hour complaining about the schedule change. Then, on the hour, they stopped complaining and allowed the substance of the meeting to be discussed and then, at the scheduled end of the meeting, they complained vociferously that there wasn’t enough time for the discussion of substantive matters. This was such a sharp, and depressing, contrast to the non-partisan approach taken in the Québec National Assembly.

Disappointment accompanied the anger. I was deeply disappointed by the new level of toxicity and dysfunction in the context of public debate. Opponents of the removal of “reasonably foreseeable” and the inclusion of the MAiD MD-SUMC sunset clause launched quite extraordinary attacks in their public engagement. An aggressive campaign was waged to get an academic journal to issue an apology for having published a paper of mine. Senior academics attacked and attempted to humiliate junior academics in public settings. Tactics were employed to undermine opponents including name-calling on social media and even in front of Parliamentary committees and other groups – including liar, delusional, ableist, racist, anti-working class, Nazi, and (incomprehensibly) rapist. Civility, collegiality, and the principle of academic freedom were breached, diminishing the possibility of constructive dialogue and having a chilling effect, especially on people just entering their fields.

Bafflement then emerged as a dominant reaction as opponents of C-7 insisted on making arguments that were, in effect, relitigating *Truchon* and sometimes even *Carter*. They made arguments grounded in claims about the evidence about, e.g., discrimination on the basis of disability (testimony of Heidi Janz, 2021a) and the relationship between suicide and MAiD (testimony of Mark Sinyor, 2021b; testimony of Scott Kim and Sonu Gaid, 2020) that had already been adjudicated under cross-examination of experts and found unpersuasive in *Carter* and/or *Truchon* (Downie & Scallion, 2021 referencing *Truchon c. Procureur général du Canada*, 2019, paragraphs 388–407, paragraphs 408–422). Making arguments that, in effect were arguments against removing “reasonably foreseeable” or even allowing MAiD at all, made no sense from the perspective of trying to have a policy impact. There were robust (lengthy, detailed, powerfully explained) court decisions already rejecting their arguments (*Carter v. Canada*, 2012; *Truchon c. Procureur général du Canada*, 2019). The Minister of Justice had decided not to appeal *Truchon* having said

it was a compelling decision that he believed they could not successfully appeal.²³ The government was not going to keep “reasonably foreseeable” in the law. And they weren’t going to recriminalize MAiD. So why did these advocates spend the little time and attention they could get from the policy-makers arguing for an outcome they weren’t going to get? Why not go for something potentially achievable (e.g., additional procedural safeguards rather than more restrictive eligibility criteria)? I still don’t know.

An Oddly Timed Intermission—Take It from Us: Lessons from Canada

Many jurisdictions in the world are today where Canada was through our prologue. With a majority of their population supportive of legalizing MAiD and with assisted dying happening (often with assistance from family members rather than clinicians) but the punishment not literally fitting the crime. Yet with law reform not forthcoming. One lesson Canada offers is to ***never give up hope or stop advocating for reform*** – keep trying to get the window of opportunity for law reform open and ***be ready*** so that when the window of opportunity cracks open, you are ready to dash through it with all of your arguments and evidence already assembled.

For those who seek reform on issues that attract the energy and attention of single-issue voters and organizations (e.g., issues relating to claims about sanctity of life such as abortion and MAiD), it is essential to ***account for the single-issue voter phenomenon*** in law and public policy reform strategy (e.g., going to court or directly to the people through referenda rather than trying to convince members of legislative bodies to lead). Of course, these strategies are only available in some jurisdictions (e.g., many countries do not have a supreme human rights-protecting instrument like the *Charter* and do not have direct legislative mechanisms like citizen initiatives).²⁴

Policy-makers should ***never forget the value of a robust consultation process***. The process led by the Québec National Assembly provided a solid foundation for public confidence in the MAiD framework that was ultimately introduced. The process led by the federal government provided a solid foundation for public confidence in the amendments to Canada’s first MAiD law introduced through Bill C-7.

Policy-makers should also ***appreciate the value of ethically-driven leadership from physicians***. The process initiated by the Québec College of Physicians removed one of the key pillars for the SCC’s decision in *Rodriguez* (the claim of widespread disapproval of MAiD from medical groups). It also introduced a comprehensive gaze that resulted in Québec’s legislation dealing not only with MAiD

²³ The Minister of Justice, David Lametti, stated “Madam Speaker, the simple fact of the matter is this: Had we appealed the decision through the court of appeal, or possibly the Supreme Court of Canada, so many more Canadians would have had to suffer for so much longer. It is that simple. That would be on a case in which we strongly believed legally we would lose on its constitutionality. The reasoning of the Québec Superior Court was compelling and it will ultimately be upheld. Why make people suffer in the meantime?” (Lametti, 2021).

²⁴ Canada has the *Charter of Rights and Freedoms*, Oregon has initiatives (explained in Legislative Committee Services, Background Brief on Initiative, Referral, and Referendum Process (September 2012) available online at <https://www.oregonlegislature.gov/lpro/Publications/InitiativeReferendumProcess.pdf>, while Australia and the UK have neither.

but with all end of life care – with the distinct advantage of improving end of life care for all Québeckers and not just those seeking MAiD.

Policy-makers should also *never forget the value of the expansive gaze that expert panel processes can afford*. Not bound by constraints of, e.g., the specifics of the case before a court or the jurisdiction of a particular legislative body, the Royal Society of Canada Expert Panel and the Provincial-Territorial Expert Advisory Group were able to situate MAiD in its broader context of end-of-life care and to address recommendations to the full range of authorities. This is critical for implementation as a coordinated comprehensive regulatory framework is essential to stakeholders knowing what is required of them and having the tools to perform their roles.

Advocates working for change through the courts should take from *Carter* case *the value of bioethicists in legal proceedings and the best ways to realize that value*. Some would say that bioethicists have no place in the courtrooms of the nation but the *Carter* case reveals the essential nature of their expert evidence – e.g., without Wayne Sumner’s cogent conceptual analysis, Justice Smith might not have concluded that there is no sustainable distinction between assisted dying and withholding and withdrawal of treatment and therefore the prohibition on assisted dying is unsustainable (*Carter v. Canada*, 2012, paragraphs 234–237, 321, 335, 339, and 351). An analysis of the judge’s assessments of the experts can also provide insight into which bioethics experts and which forms of ethics evidence may be more persuasive to the courts (Downie, 2018).

For bioethicists in other countries, another lesson from Canada’s experience is again about the role and admissibility of expert evidence in bioethics in courts as well as the ways in which bioethicists can maximize their usefulness to the court (*utility is the goal as advocacy is not part of the role of an expert witness – they are legally obligated to be neutral and objective*).

The *Truchon* case provides explicit lessons for bioethicists on being an expert witness. Justice Baudouin included in her reasons in *Truchon* a lengthy explanation (too long to include in this paper) as to why certain ethics experts were unpersuasive and ineffective (Downie & Scallion, 2021). Her reasons can be directly translated into lessons. *Don’t opine on matters that can be jurisdiction-specific without having a robust understanding of the laws in that jurisdiction*. Even if knowledgeable about bioethics, *don’t engage as an expert witness opining on matters that can be jurisdiction-specific without having a robust understanding of reality on the ground there*. No matter how qualified, *don’t base your expert opinions on hypotheses, extrapolations from the data, or theoretical evidence*. *Don’t “elevate anecdotal and still-marginal cases to the rank of broad principles applicable to the situation prevailing in [the jurisdiction in question].” Be informed about “simple facts” about the parties in the case. Don’t leave the court thinking that your observations are “within the ranks of mere conjecture or anecdote” and don’t describe them as “robust findings.”*

Epilogue

Further law reform may come about as a result of two processes mandated in C-7. First, “an independent review to be carried out by experts respecting recommended protocols, guidance and safeguards to apply to requests made for medical assistance

in dying by persons who have a mental illness” (Bill C-7, 2020c: s.3.1). Second, “a comprehensive review of the provisions of the *Criminal Code* relating to medical assistance in dying and their application, including but not limited to issues relating to mature minors, advance requests, mental illness, the state of palliative care in Canada and the protection of Canadians with disabilities” (Bill C-7, 2020c: s.5) to be undertaken by a Joint Committee of the House and the Senate.

What, if anything, the federal government will do about all or any of these issues and in response to the two reports due from these bodies in Spring 2022, remains to be seen. Plays don’t usually have sequels but, in this case, there will most certainly be one – one in which bioethicists will play their role and from which other jurisdictions will be able to take lessons.

Appendix A

Comparative at-a-Glance Chart of Relevant Variables

✗ = do not permit access to MAiD

✓ = permit access to MAiD

N/A = position not taken

RSC = Royal Society of Canada Expert Panel: End-of-Life Decision Making Report (2011)

Carter = *Carter v. Canada* (2015)

PTEAG = Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying Final Report (2015)

Joint Committee = Special Joint Committee on Physician-Assisted Dying “Medical Assistance In Dying: A Patient-Centred Approach Report of the Special Joint Committee on Physician-Assisted Dying” (2016)

C-14 = *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* (2016)

Truchon = *Truchon c. Procureur général du Canada* (2019)

C-7 = *An Act to amend the Criminal Code (medical assistance in dying)* (2020)

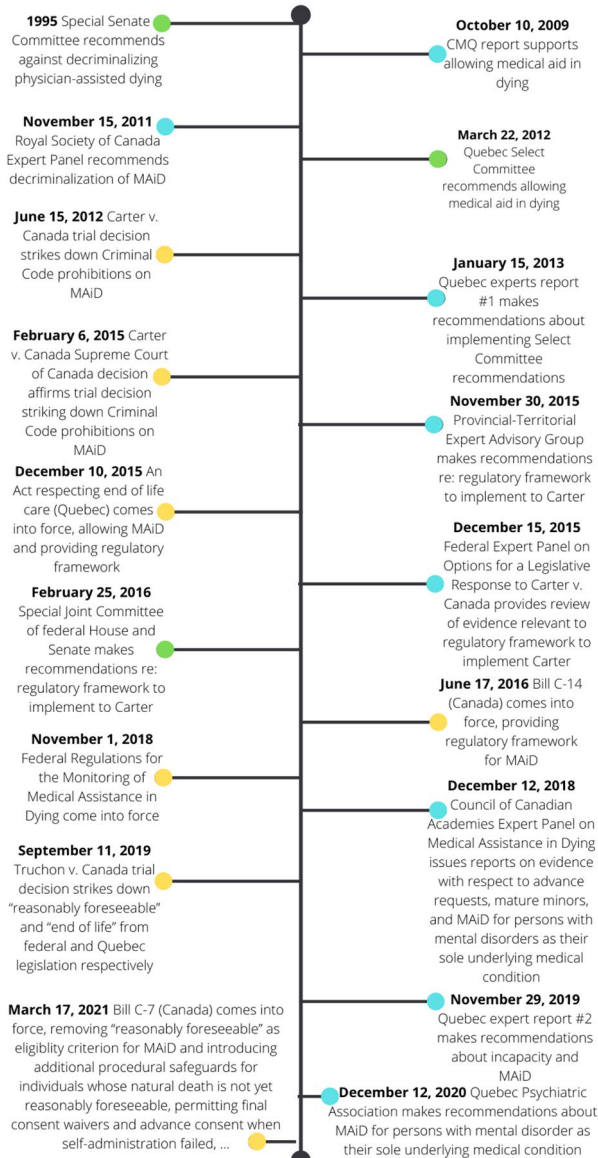
	RSC	<i>Carter</i>	PTEAG	Joint Committee	C-14	<i>Truchon</i>	C-7
Not reasonably foreseeable	✓	✓	✓	✓	✗	✓	½✓ ½✗
Mature minors	N/A	N/A	✓	✓	✗	N/A	✗
MD-SUMC	✓	✓	✓	✓	✓	✓	✗
Advance requests	✓ some	N/A	✓ some	✓ some	✗	N/A	✓ some

Appendix B

LEGAL JOURNEY OF MAID IN CANADA

Legend

- legal reform
- expert report
- legislative committee
- report



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